CORPORATE POWER AND THE AMERICAN DREAM

Just Health Care

Corporate Power and the American Dream:

Just Health Care

The Debs-Jones-Douglass Institute is a non-profit organization which carries out cultural and educational projects. The purpose of the DJD Institute is to assist in the establishment of a society in which equality of opportunity and citizenship is assured, through providing education using the fullest range of methods, curricula and delivery systems. The Debs-Jones-Douglass Institute is involved in educational/cultural projects on health care, higher education, occupational health and safety and genetics. It has sponsored national radio call-in programs and the Washington, D.C. Labor Film Fest. The DJD Institute is affiliated with the Labor Party.

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For more information contact us at:

Debs-Jones-Douglass Institute
1532 16th Street, NW
Washington, D.C. 20036
202-234-0040
www.djdinstitute.org

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Introduction

U.S. Health Care: A Commodity, Not A Right

The United States spends more than twice as much on health care than any other country, yet ours is the only country without universal health care. The United States spends almost $4,500 per person per year on health care and still has over 42 million uninsured, and most of those with insurance are underinsured. Canada only spends around $2,300 per person and yet guarantees quality health care for all its residents. Why is the delivery of health care so different in the United States? A big part of the reason is that health care in the United States is dominated and run by corporations. This means that health care is not considered a right for all citizens. Health care is treated like any other commodity in the market – those who have the most money get the most and best of it. Corporations, in the form of managed care companies, increase their profits, not by increasing quality, but by passing their costs on to us through a long list of profit-making tactics, such as denying quality care, increasing the cost of premiums and deductibles and avoiding the sickest altogether.

The Time Is Right For Just Health Care

This curriculum supports a fundamental change in America's health care and advocates for a national health insurance program similar to the Canadian system. The time is right for Just Health Care:

Because the abuses of managed care have grown. Most people are fed up with managed care's attempts to manage costs by denying or delaying all aspects of care, including referrals, medications, hospital admissions, therapy services, etc. But perhaps the most egregious abuse has been that of HMOs taking billions of dollars out of Medicare, then dropping almost one million seniors once the profits dried up.

(continued)

Introduction

Because having a job, even a full-time job, does not mean workers and their families will have health insurance. Almost half of the U.S. workforce is employed in retail, health and business service jobs which are the lowest-paying and the least likely to offer health insurance. Sixty-five percent of workers in retail jobs and 46 percent in health and business service jobs do not have job-based health coverage. Furthermore, 53 percent of full-time workers with incomes under $35,000 per year don't have employer-based health coverage. And, over one-third of Hispanic workers with full-time jobs don't have health insurance. The notion that Americans get their health coverage through their jobs is indeed a myth and is a significant reason why employer-mandated health insurance is not the answer to health reform.

Because more costs of health coverage are being passed on to workers, affecting their health and quality of life. As the costs of health care increase (the cost of health premiums has gone up 10 to 30 percent) employers are increasing the cost of premiums, raising co-payments and deductibles, reducing benefits and threatening to stop coverage altogether. Today, over 80 percent of workers with job-based insurance must contribute to their family coverage (around $1,500 – up 50 percent since 1980). The result is that one out of every four adults with year-round, employer-provided insurance report not seeking medical treatment because of costs or having problems paying for medical care. About half of the million Americans filing for bankruptcy last year (the insured middle class, not the uninsured) did so because of medical expenses.

(continued)

Introduction

Because the administration, marketing and other bureaucratic costs of insurance companies are eating up more and more of insurance premiums, at the expense of direct care. In the United States, total health care costs are about $1.2 trillion, 13 percent of the gross national product. About $300 billion of health care costs (25 percent) is spent on billing and administration. In contrast, Canada's health costs are about 9 percent of their gross national product with only 11 percent of health funds going to billing and administrative costs. The U.S. spends about $1,080 per person maintaining our health care bureaucracy; Canada spends only about $223 per person. In the United States, insurance companies take anywhere between 14 and 30 percent of every premium dollar for their overhead and profits, compared with the government-administered Medicare program which runs at about 2 percent overhead. By eliminating the high administrative costs and profits in our current system and having the wealthy pay their fair share, the United States can provide health care to every U.S. resident for the same total amount of money that we now spend.

Because the current suggested changes to health care will cover only small numbers of people, keep the basic structure of for-profit insurance companies in place, continue to stretch Medicaid and public hospitals, squander additional money on paperwork, not address rising costs and cost large amounts of money. There are many band-aid approaches to health care reform on the political agenda today. These include: employer-mandated coverage, tax credits and deductions, expanding Medicaid and the CHIP program for children, and medical savings accounts. Research has shown that these responses will assist only a small number of the more than 42 million uninsured and cost billions of dollars. However, these piecemeal approaches continue to be pursued because they avoid the need to grapple with the difficult financial and ideological questions associated with national health insurance, and they avoid challenging the corporate power of the more than 1,500 insurance companies.

(continued)

Introduction

Because we need to build coalitions for an effort that could take many years. Achieving national health insurance will be a long, arduous battle, given the strength and determination of the opposition. A recent *Nation* (May 14, 2001) profile of Grover Norquist, Washington's leading right-wing strategist, highlights the long-range view the right has taken – with increasing success, as witnessed by the huge tax cut that favors the wealthy, the roll-back of women's reproductive rights and plans for the privatization of Social Security. According to the article, Norquist has a time line starting in 1980 and going to 2040, with rows of projects – some nearly completed, some not to begin for decades. His statement, "My goal is to cut government in half in 25 years to get it down to the size where we can drown it in the bathtub," is an indication of what we are up against.

Because national health insurance is the alternative that makes sense to the American public. National health insurance makes health care a right for every person. It breaks the unequal, tenuous relationship between a family's health care, the employer and the condition of the economy. It eradicates profit-making and cost-cutting as the rationale for health care decisions. It places medical decisions back in the hands of physicians and their patients. In fact, 82 percent of both physicians and the public support "fundamental change or complete rebuilding of the entire health care system."

How to Use This Workbook:

The Small Group Activity Method

This Workbook uses the Small Group Activity Method – a participatory, non-lecture training method. Too often, lecture-style teaching promotes passivity and boredom and, as we all have experienced, too many lectures "go in one ear and out the other." The Small Group Activity Method asks people to participate in their own training by solving real problems, based on their own knowledge and experience. This method is based on the premise that it is the participants themselves – whether they are workers, community activists or adult learners – who best know the problems and solutions to their workplace and community issues.

The Small Group Activity Method is based on Activities. Each of the five Activities in this workbook takes approximately 45 minutes to one hour to complete. Each Activity has a common basic structure: small group task(s), report-back, and summary.

Small Group Tasks: In each workshop, participants are asked to sit in small working groups, preferably at round tables to facilitate discussion. For each Activity, the working groups are asked to do a set of tasks by looking over factsheets and by calling on their own experiences and judgement. The idea is not to compete with each other but to work together to solve the task through discussion and debate. There are no right or wrong answers to the tasks.

Report-Back: For each task, the group selects someone to record the group's discussion and answers. The recorder from each small group reports their group's work during the report-back following each task. The workshop facilitator records each group's report on large pads of paper in front of the workshop so that everyone can refer to them. After the report-back, the workshop is open for general discussion about the topic.

Summary: After the report-back, the facilitator(s) highlights the key points and brings up any issues that may have been overlooked.

The Facilitator: Each Activity is led by one or more facilitators, who are not professional teachers or experts. They are workers and community activists who have participated in a training course about heath care and have experience in facilitating small group work. The facilitators have been trained to structure the discussions so that everyone learns from the materials and from the collective knowledge of the whole group.

Activity 1

Problems of Health Care: The Corporate Takeover of U.S. Health Care

Purpose: **To examine what the corporate takeover means for the whole system of health care delivery, to discuss the problems of our health care system and to explain their root causes.**

When we talk about the health care system in the United States, we often focus on the problems we have with our insurance, our doctors and the cost of our prescriptions. But the health care system is more than this. It is a vast network of hospitals, clinics, public health facilities, home health care, emergency facilities, mental health care, etc. This whole system – whether for-profit or non-profit – is being altered by corporatization.

There is one task in this Activity.

Task 1

In your small groups please answer the three questions below. Remember to choose someone to take notes about your discussion and to report back to the large group. When answering the questions, please refer to Profit-Making Tactics 1-15.

Questions

1. **Make a list of the problems you, your family, friends or co-workers have experienced with the health care system. These problems can be as "minor" as being put on hold whenever you try to call your health insurance company, or, as "major" as treatment denied.**

2. **Make a list of what you think are the *problems* with our health care system as a whole.**

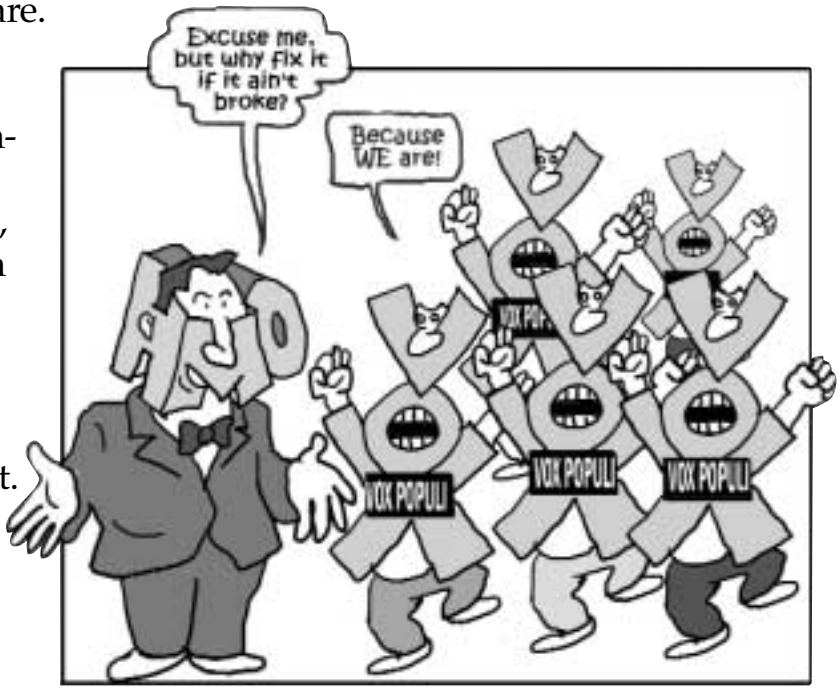
3. **Make a list of what you think are the *causes* of the problems in our health care system.**

Factsheet 1

The Public Says Rebuild Our Health Care System

The Public Supports Changing Our Health Care System[1]

- ❒ 79 percent of Americans believe that access to health care should be a right.
- ❒ 85 percent of Americans agree that "much of the expense of health care in this country is created by insurance bureaucracy."
- ❒ 60 percent say managed care programs have decreased the quality of health care.
- ❒ 64 percent of the votes cast in Alachua County, Florida in November 2000 support a non-binding referendum favoring legislation to create universal health care.
- ❒ In Massachusetts, all three of the non-binding initiatives in November 2000, won for legislation creating universal health care in two state house districts and one state senate district.
- ❒ In June, 2001, the state of Maine passed the first universal single-payer bill in the nation.



Factsheet 1

Physicians, Nurses and Patients Want Health Care Reform

- U.S. physicians' hostility to the current managed care health system has reached an all time high. No longer are patients the only ones unhappy and angry with the health care system. Today, according to a recent Harris poll, **82 percent of both physicians and the public support "fundamental change or complete rebuilding of the entire health care system."**[2]
- 71 percent of Oregon physicians think the Oregon Medical Association should consider a government health care program.[3]
- The 180,000 member American Nurses Association endorsed single payer health care as the most desirable option and stated that health care is a fundamental human right at their annual meeting in June 1999.[4]

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Factsheet 1

Workers Take Action Against Shifting Burden of Health Care Costs[5]

- Nearly 40 truck drivers in Huntington, West Virginia, went on strike after Coca-Cola Bottling Company proposed raising health insurance premiums to $1,040 per worker per year from $104.
- Almost 17,000 Boeing engineers, members of the Society of Professional Engineering Employees in Aerospace IFPTE Local 2001, walked off the job for 40 days, opposing management's plan to pass along 10 percent of the monthly insurance premium. Boeing backed down.
- More than 90 production workers at a macaroni plant in Omaha, Nebraska walked off their jobs for almost three months after the company proposed eliminating retiree medical benefits. The company agreed to boost pensions to cover costs.
- About 50 workers at a credit union in Allentown, Pennsylvania went on strike for nearly three months, in part because the company wanted to increase deductibles from $100 to $300. The company retracted the demand.

Factsheet 2

HMOs and Managed Care Companies Put Profits Before Patients

The following examples capture the reality of our corporate dominated health care system – it is profit-driven. Every campaign, strategy, and action taken by these corporations is directed at cutting costs and increasing profits to the detriment of providing the best possible services to patients.

The fiscal responsibility of those who run corporations is to produce revenue and maximize profits for their stockholders. This means that the profit-making needs of insurance companies, drug companies, other corporate owned health services and all their CEOs must come before the needs of their patients.

No faith in managed care

Seventy-two percent of those in strict managed care plans (and 58 percent of the general population) say they are worried that if they become sick their health plan will be more concerned about saving money than providing the best treatment.[6]

Physicians accuse HMOs of fraud

The 34,000 physician members of the California Medical Association recently filed a civil racketeering suit against three managed care companies accusing them of "using coercive, unfair, and fraudulent means to dominate and control the physician-patient relationship for their own financial gain, to the detriment of both patients and physicians."[7]

Federal lawsuit filed against HMOs

The state of Connecticut is filing a federal lawsuit against four of the state' s largest HMOs claiming that, "They have forced people to accept less-effective care simply so the company can increase its profits."[8]

Factsheet 3 The Corporatization of Health Care Dominates Our Lives

The corporatization of health care has a profound two-pronged effect on our daily lives.

1. Insurance corporations determine all aspects of our health care.

Health insurance providers have become corporations operating under the profit-motive. This affects every aspect of how we receive treatment, where we receive it, how much we pay, who is eligible for treatment, how our physicians relate to us, and the quality of our care.

2. Employers have become gatekeepers to our health care needs

In the United States, unless you are elderly, poor or disabled, health insurance is tied to employment. Those of us who have insurance most likely receive it through our jobs. The demands of corporate health care have made our employers the gate-keepers for all our medical needs. And, the threat of losing health coverage prevents us from leaving a job, taking work-actions, or striking.

As a result, our health history and needs are becoming linked with our employment. Large employers have personnel practices that require blood, drug and urine testing of employees and potential hirees. Workers often must provide information about heart disease, genetic disorders, cancer, and lifestyle, and reveal what prescriptions and other medications they are taking. Medical facilities are built on-site to cut costs. Our mental health counseling becomes part of the company's record. On the one hand, our jobs determine the level of health care we and our families receive. On the other hand, our health information often becomes the basis of whether we are hired or are allowed to keep our jobs.

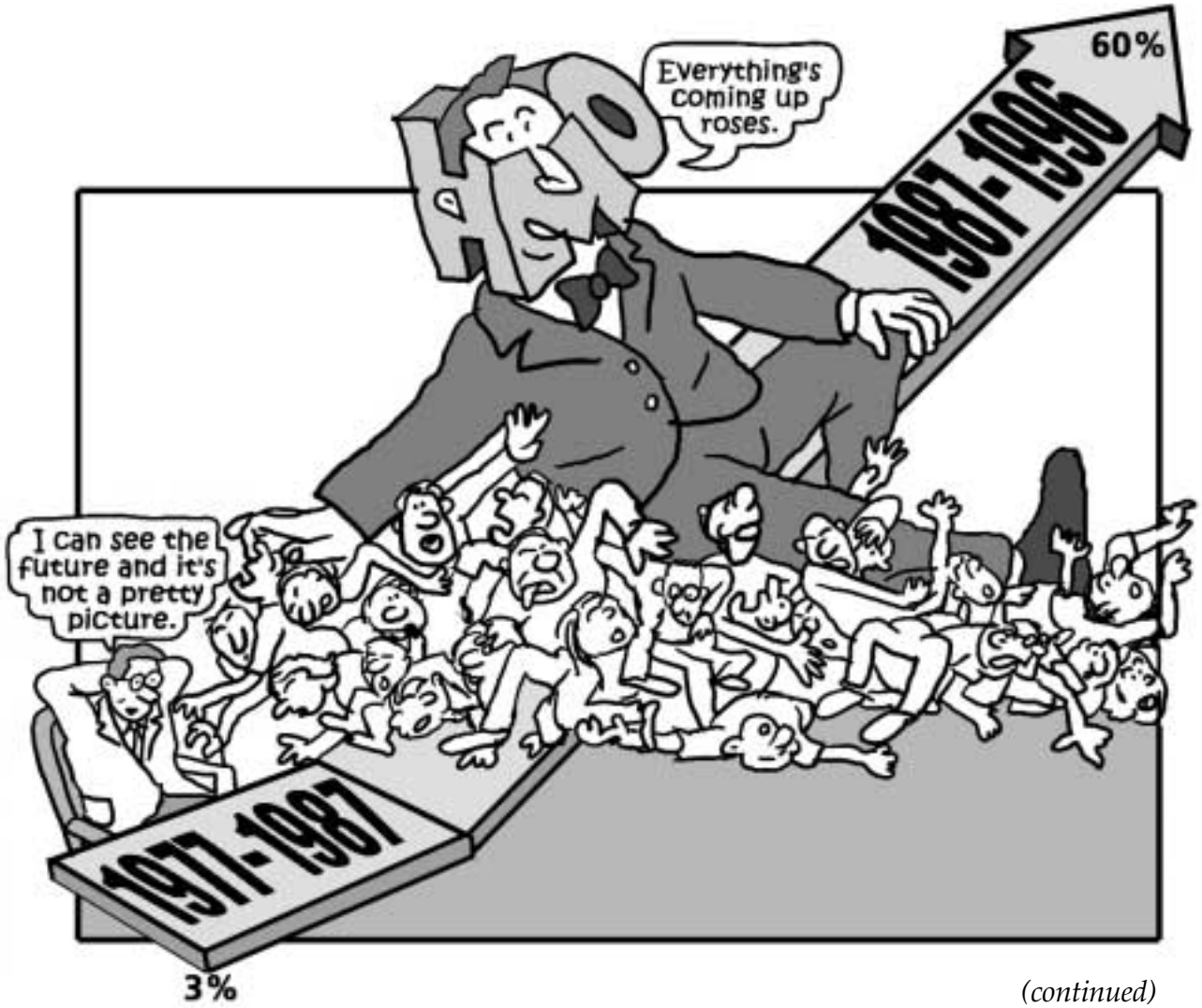
Factsheet 4

For-Profit HMOs Dominate the Health Care System

PROFIT TACTIC

Until the late 1970s, most of us were still seeing physicians who operated on the basis of fee-for-service. Only about three percent of those covered by health insurance were in managed care. Today, over 60 percent of the insured population is covered by HMOs.[9]

Percent of Insured Population Enrolled in HMOs



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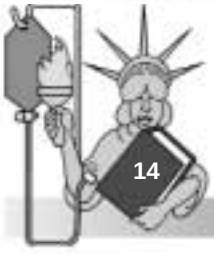


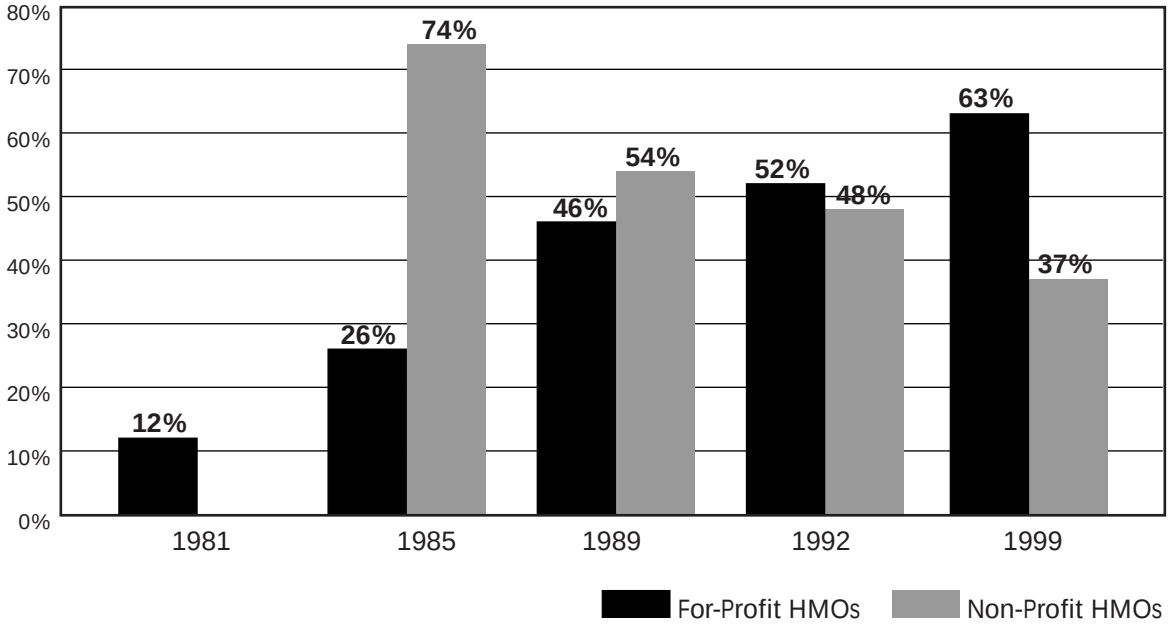
Factsheet 4

Sixty-Four Percent of Insured Population is Enrolled in For-Profit HMOs

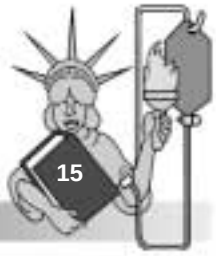
Not only has managed care taken over health care, but **for-profit HMOs** have eaten up the non-profits and now dominate the managed care delivery system.

As the table below shows, today 63 percent of all HMO patients are in for-profit plans, up from twelve percent in 1981.[10] There has, indeed, been a corporate take-over of our health system.

For-Profit HMOs Have Taken Over the Market



(Percent of HMO Enrollment)



Factsheet 5

Managed Care's Control Over the Health Care System = Huge Profits

The managed care industry is generating huge revenues and profits by taking control over more and more doctors, hospitals, nursing homes and patients.

As the industry grows, its revenues are expected to top $176 billion in 2000. Almost all of this increase will come from higher rates and pulling away from "unprofitable" Medicare markets.[11] **The managed care industry's profits are expected to top $3 billion in 2000, up 60 percent from 1999.**[12]

As these corporations form and amass more and more power, they will continue to dictate how **they** will deliver **our** healthcare to **their** benefit.

Revenues and Profits of the Top Ten Managed Care Companies, 1999[13]

Company	Revenues (total income)	Profits (income – costs)
Aetna	$ 22. billion	$ 717 million
Cigna	$ 21. billion	$1.8 billion
United Health Group (1)	$ 19.5 billion	$568 million
Columbia/HCA Healthcare*	$ 16. 6 billion	$657 million
Tenet Healthcare*	$ 10.9 billion	$249 million
Humana (2)	$ 10. billion	$382 million
Pacificare Health Sys. (3)	$ 10. billion	$279 million
Foundation Health Sys.	$ 28.7 billion	$142 million
Wellpoint (4)	$ 27.5 billion	$279 million
Oxford	$ 4.2 billion	$320 million

(1) One of the largest Medicare HMOs.
(2) Formerly HealthCare Corp.
(3) One of the largest Medicare HMOs.
(4) Commercial market.
* Hospital firms

Factsheet 6

Putting the Bottom Line First

A confidential Kaiser Permanente Southern California Region Business Plan for 1995 through 1997 reveals the mentality of corporate cost-cutting in the delivery of patient services.[14] Below are some excerpts from the plan.

Kaiser's Cost-Cutting Tactics:

- ❒ Reducing the number of patients hospitalized by more than 30 percent;
- ❒ "Shifting surgical cases from inpatient to outpatient (i.e., gall bladders, mastectomy/lumpectomy, appendectomy)";
- ❒ Rationing high-cost prescription drugs;
- ❒ "Aligning physician bonus pay and leadership compensation to target achievement," (i.e., giving doctors bonuses for reducing hospital admissions);
- ❒ "Implementing care paths for chest pain and stroke," (i.e., discharging patients early or removing them early from Intensive Care);
- ❒ "Reducing staff in surgical and primary care specialties...";
- ❒ Requiring "alternatives for Skilled Nursing Facility admissions and lengths of stay," (i.e., moving patients into nursing homes or their own homes).

Factsheet 7

HMOs Control the Doctor Relationship

HMO policies, such as capitation and financial incentives, force doctors to pit their own financial interests against their patient's needs.

> In a study of almost 800 physicians, 57 percent said they felt pressure from their managed-care company to limit referrals, 75 percent felt pressure to see more patients per day. Such pressures often compromised patient care.[15] Similarly, a recent survey of 59,000 Americans found that 44 percent thought that insurance companies do influence doctors' care decisions.[16]

Capitation or Lump-Sum Payment

With a capitation contract, doctors, medical groups and hospitals receive a lump sum (or per head, thus "capitated" rate) from the HMO for every patient under their care regardless of how much treatment is needed. In 1997, one-third of the 483,000 physicians in the United States had capitation contracts with HMOs.[17] The medical group, doctor or hospital gets to keep whatever money is not spent. However, in many instances the rate the HMO offers is extremely low, forcing the doctor or medical group to cover part of the costs of treatment. This system by its very nature, and in spite of the doctor's best intentions, aligns the health care provider with the interests of the corporate HMO, not with the patient. Physicians are pressured into thinking twice about making expensive referrals and tests and it is in their own interest to see as many patients as they can.

Bonuses

HMOs profile and rank doctors according to their use of high-cost drugs and procedures. Those who are the most thrifty may receive bonuses. For example, according to an economic profile prepared by the Alta Bates Medical Group in the San Francisco Bay Area, a physician's use of more expensive drugs cost him $965.18 per month.[18]

Factsheet 8

HMOs Deny and Delay Medical Care

A medical reviewer for one of the largest HMOs put it this way:

"The patient was a piece of computer paper... The 'clinical' goal was to figure out a way to avoid payment. The 'diagnosis' was to DENY… whether it was non-profit or for-profit, whether it was a health plan or hospital, I had a common task: using my medical expertise for the financial benefit of the organization, often at great harm and potentially death to some patients."[19]

– Dr. Linda Peeno, medical reviewer for Humana and medical director at Blue Cross/Blue Shield Health Plans.

One of the basic premises underlying managed care is that costs can be controlled by having a veto over doctor's treatment decisions. Second-guessing our doctor's decisions is one of managed care's most pernicious tactics to cut their costs and increase their profits.

Cost-Cutting Tactic: Deny or Delay Care

- ❒ HMOs hire "medical directors" to decide whether or not our physician's treatment decisions will be paid for. These medical directors are not always MDs; they can work from another state and not be licensed to practice in "our" state, and most importantly, they make life and death decisions without examining patients.[20]
- ❒ Often, those providing the authorization for treatment are clerks or nurses who have the power to override doctors' decisions in emergency cases.

(continued)

Factsheet 8

HMO Medical Director Delays Care

Christine deMeurer's doctor recommended a life-saving bone-marrow transplant which was a covered benefit by HealthNet. But the medical director at the HMO initially overruled her physician and denied the process. After a long delay and much hassling with HealthNet, she eventually received the treatment, which was then paid for by the university doctors she was seeing. Her cancer went into remission and she lived two more years. Her family wonders what toll the waiting and wrangling had on her life. HealthNet's Medical Director said, "HealthNet was doing what was best for the patient, which was to deny treatment as investigational, and which in the end was proven the right decision." In other words, because she died, HealthNet was right in denying the treatment.[21]

HMO Phone Representative Denies Care

When James Adam, six months old, had a 104 degree fever and was limp, his mother called Kaiser. The emergency phone representative sent the family not to the closest emergency room but to one 42 miles away, where Kaiser received a discount. When they arrived at the hospital the baby was in cardiac arrest and, because blood was no longer flowing to his extremities, his arms and legs had to be amputated. Kaiser's Medical Director said that the delay did not make a difference and that quality pediatric care was most available at the hospital to which the Adams were sent.[22]

These are just two of numerous, similar stories.

Factsheet 9

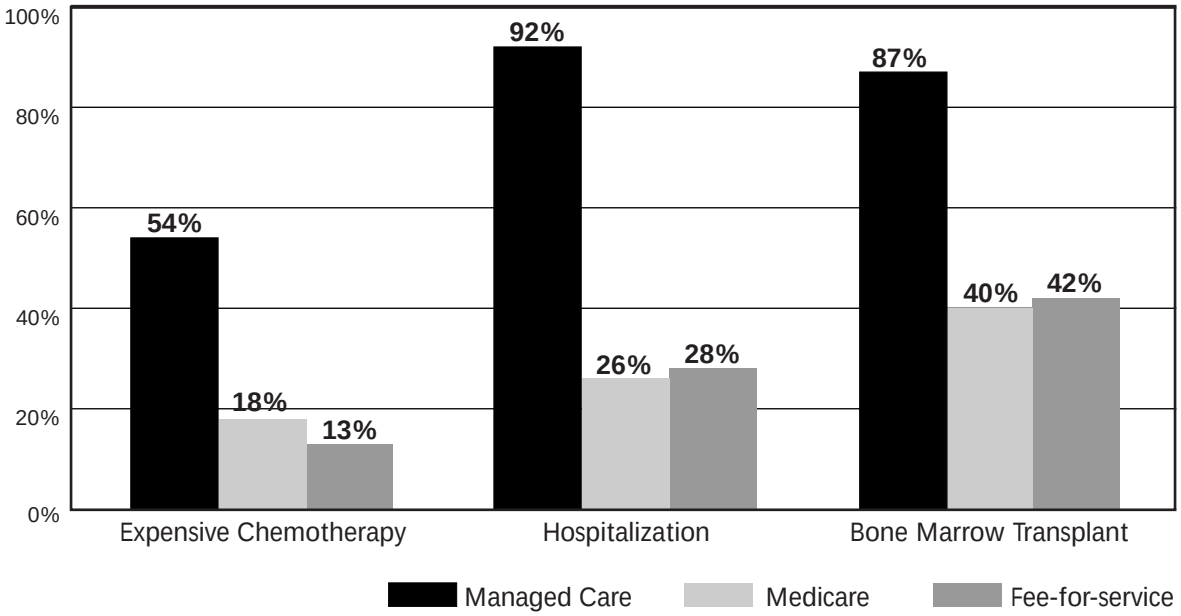
Holding Back Care from Those Most Sick

As cost-cutting measures of managed care take over our health care system, the very sick who require expensive care are among the first to suffer. Managed care corporations can cut their costs and increase their profits if the very ill and costly patients become dissatisfied and leave the plan. Although HMOs may encourage inexpensive preventive care to the healthy, they have put great pressure on the treatment of the most ill – cancer patients.

The chart below shows the results of a survey of 329 oncologists (cancer specialists) who indicated that they were hesitant to prescribe expensive treatments for their HMO patients. For each treatment, managed care patients, relative to Medicare and fee-for-service, were less likely to receive the costly care.[23]

Cancer Specialists Less Likely to Prescribe Costly Care for HMO Patients

(Percentage of Doctors that Hesitated to Treat)



Factsheet 10

Closing Emergency Rooms

One of the most devastating tactics managed care uses to cut hospital costs is the closing of Emergency Rooms – because emergency care is not a moneymaker for a hospital. In just a decade, from 1988 to 1998, 1,128 Emergency Rooms have been closed nationwide.[24]

Closing ERs Cuts Costs

By closing Emergency Rooms, a hospital can cut the costs of maintaining an intensive care unit, the need for specialized staff, and the amount of emergency and high tech equipment. With the elimination of these services, closing the emergency department is often "step one" in the process of completely eliminating acute care services altogether, followed by closure of the entire hospital.

Closing ERs Gets Rid of the Uninsured

And, not insignificantly, by eradicating emergency room services, a hospital can eliminate the largest group of ER users – the "unprofitable" uninsured. Nearly one in four patients seen in California ERs are uninsured. The cost of treating the uninsured is one reason about 20 California hospitals closed their ERs in the last two years.[25]

Managed Care Created the Problem

The closing of emergency rooms is part of a vicious cycle. Both the uninsured and insured patients have increased their use of emergency rooms. With managed care, insured patients are becoming so frustrated with waiting for an appointment to see their primary physicians and to get referrals that they turn to emergency rooms. HMOs often refuse to pay for emergency treatment, pay late or pay too little, forcing patients or the hospital to pick up the tab.

Factsheet 11 Cutting Back on Professional Nursing Staff

"He lay unattended, neglected, and forgotten at an HMO hospital and quietly bled to death. In spite of deteriorating vital signs and complaints of severe pain and abdominal spasms, no physician was called in. Nursing cutbacks on the floor, due to corporate cost-cutting, prevented a nurse from even checking on Dwight. At the most critical time, after he complained of excruciating pain, Dwight went unmonitored for over an hour and a half. When he finally was checked, he was dead. In less than five hours after leaving the recovery room from a routine elective surgery, my husband died from internal hemorrhaging."

– Suzy Lobb's statement about her husband [26]

Staff Cutbacks Result in Increased Medical Errors

A recent study estimated that 44,000 to 98,000 Americans die each year as a result of medical errors. Even using the lower estimate, more people die per year from medical errors than from motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516).[27]

Why Are These Errors Happening?

Medical errors have corporate origins. Errors are happening, in part, because hospitals are downsizing their professional nursing staff in order to cut costs and maintain their HMO contracts. Registered nurses are in short supply and those who remain are overworked. Cutbacks are taking the form of:

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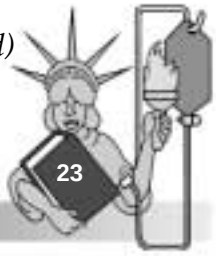


Factsheet 11

- **Mandatory Overtime.** To avoid hiring enough skilled nurses, some hospitals are requiring mandatory overtime – requiring nurses to work up to eight hours overtime after a regular eight hour shift.[28] Overtired and overworked workers in any profession are more likely to make mistakes.
- **Substituting Untrained Employees for Skilled Nurses.** RNs are being replaced with lower-waged employees who are not trained or licensed to perform tasks that should be done only by a professional – such as starting IVs or taking care of wounds. "Housekeepers" (qualifications: high school diploma or equivalent and experience in housekeeping, food handling, transporting supplies, or decontaminating containers) are now called "service-partners" and can respond to patients call lights. [29]
- **Just-in-time Staffing.** Rather than hiring adequate permanent staff, hospitals bring in just enough nurses each day to cover anticipated patient loads. If the day is busier than anticipated, nurses are unable to respond to individual patient needs, and can't even respond to emergencies.
- **Investments to Improve Billing, not Quality of Care.** While hospitals are cutting back on essential staff, they have invested billions in computer systems used for billing, but little for computer systems to improve quality – e.g. programs to prevent prescribing lethal dosages or combination of drugs.

More Nurses: Better Care[30]

A one hour increase in nursing hours per patient is associated with:

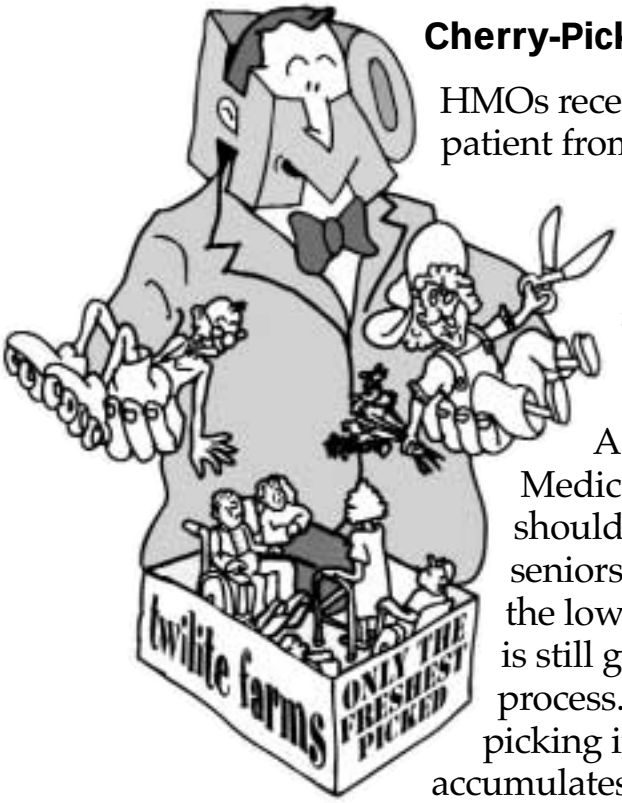
- 8.4% decrease in post-op pneumonia
- 5.2% decrease in post-op thrombosis
- 3.6% decrease in post-op pulmonary problems
- 8.9% decrease in post-op urinary tract infections

Factsheet 12

HMOs Cherry-pick Then Dump the Elderly But Give Top Execs Millions

Managed care will do whatever it takes to maintain profits. Managed care companies say that the "costs and losses" in the Medicare market (not enough profits) are forcing them to withdraw coverage for over 900,000 elderly and disabled (nearly one-sixth of the 39 million HMO Medicare clients).[31] At the same time, these corporations continue providing multi-million dollar compensation packages to their top executives.

Company (partial list) [32]	Medicare HMO Withdrawals	Salary of Top Executives, 2000 [33]
Aetna	Exiting 11 states affecting 355,000 members	$ 12.7 million
CIGNA	Exiting 11 states with 104,000 members	$ 24.7 million
United Health Care	Exiting 21 counties with 56,000 members	$ 54.1 million



Cherry-Picking, Then Dumping Seniors

HMOs receive approximately $550 per month per patient from Medicare even if no medical treatment is required. The companies keep every dollar they do not spend on their elderly clients. At first, HMOs increased their profits by soliciting the most healthy seniors while ignoring those who might cost them more in services. Monitoring by the Government Accounting Office in 1997 disclosed that Medicare paid HMOs $1 billion more than it should have, due to HMOs "cherry-picking" those seniors whose health care costs were expected to be the lowest.[34] Recent studies indicate cherry-picking is still going on. The withdrawals are still part of this process. If an HMO doesn't succeed in cherry-picking in one region, and therefore accumulates expensive, unprofitable patients, it simply withdraws from that one area.

Factsheet 13 Downsizing Medical Treatment

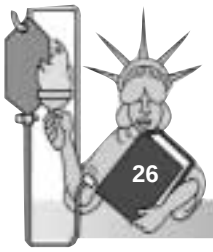
Decisions about our health are in the hands of a Seattle-based consulting and actuarial firm whose purpose is to cut the costs of delivering medical treatment by downsizing on services. The consulting firm, Milliman & Robertson, produces a manual that is used by most insurers, hospitals and HMOs. The manual lists generic guidelines that are used to determine the length of hospital stays, to either deny or authorize payment for treatment, and to determine how patients are treated at all stages of their care.[35]

The 400-page *Milliman & Robertson* Manual – dubbed "medicine-by-numbers" and "cookbook medicine" – is used to override the decisions of our medical providers.

Some of *Milliman & Robertson*'s guidelines:[36]

- ❒ One day in the hospital for diabetic coma in children.
- ❒ Cannot stay more than one day in hospital for vaginal delivery.*
- ❒ Two hospital days for a bone infection in children.
- ❒ Three hospital days for bacterial meningitis for children.
- ❒ Mastectomies should be performed on an out-patient basis.*
- ❒ Cataracts should not be removed in more than one eye unless patient is young and needs both eyes for work.

* Amended after public outcry.



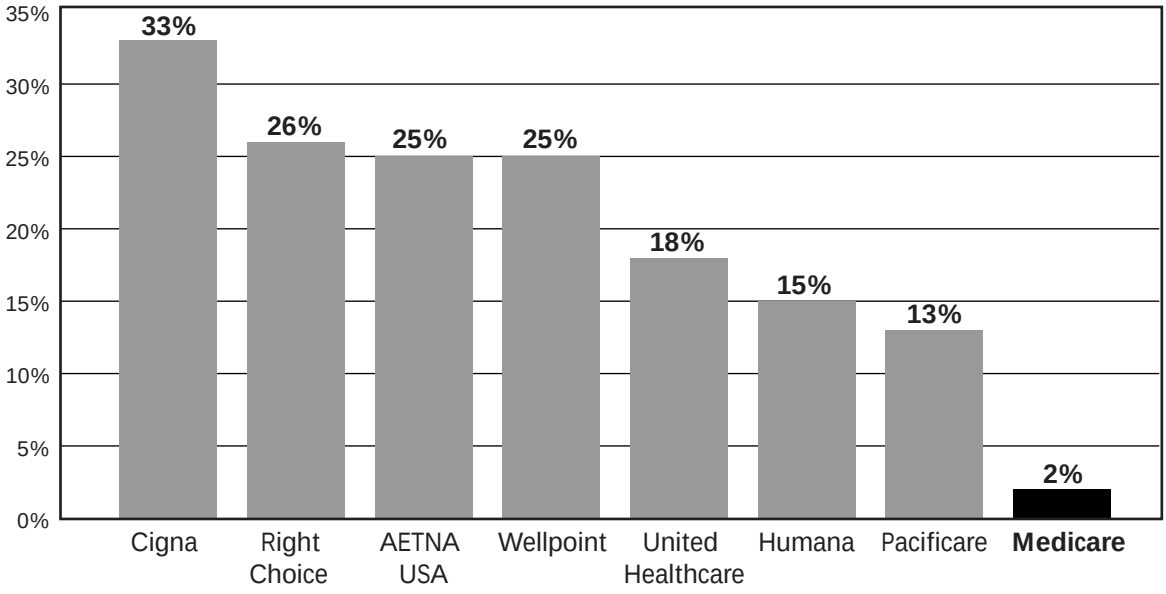
Factsheet 14

Taking Large Chunks of Premiums for Overhead and Profit—Not for Direct Services

What happened to the claims that corporate managed health care could deliver quality medical care at reasonable costs? What's happening to all the money?

A large chunk of our premium dollars goes to maintain managed care's army of bureaucrats whose purpose is to scrutinize every aspect of care in order to eliminate as much as possible, and then to make it look good. The money covering overhead and profits is money that is not going to direct care. As the table below shows, the government-run program, Medicare, operates with a little over two percent for overhead costs. Compare this with private HMOs which can spend over 30 percent for their overhead and profits.

Percent of Premium HMOs Take for Their Overhead and Profits[37]



* Overhead includes items such as CEO salaries, marketing, public relations, reviewers – anything not directly related to care.

Factsheet 15 Pill-Splitting: And We'll Throw in the Razor

A class action suit has been filed charging the country's largest HMO, Kaiser Permanente, with violating California law by forcing its members to split prescription pills. The suit says that Kaiser's pill-splitting policy endangers patients' health solely to enhance their profits. Kaiser requires splitting of a variety of pills, including blood pressure pills/medication, anti-depressants and certain antibiotics.[38]

Kaiser profits from the fact that smaller dose pills of most prescriptions cost Kaiser almost as much as the larger dose version. Kaiser makes patients prescribed the lower dose pills split the larger dose pills, and pockets the difference. In some cases, Kaiser even supplies the razor blade for splitting the pills.

Pills split unevenly, crumble and shatter, resulting in overdoses and underdoses. As a result, dosages can vary up to 40 percent. Pill-splitting can be very difficult for many elderly patients, those with hand tremors, those with cognitive or visual problems, and confusing for those who take many medications.

Other HMOs, including Foundation Health Systems, United Healthcare and WellPoint Health Networks also are asking patients who take antidepressant medicines to buy the less expensive higher dose pills and then chop them in half.[39]

Factsheet 16 Delivery of Lower Quality Medical Care

The upshot of the corporate take-over of our health care system is lower quality medical care for us and our families. A recent study of 329 HMOs in 45 states concluded that for all 14 quality-of-medical-care categories analyzed, for-profit HMOs scored lower than not-for-profit ones.[40] For-profit ownership of an HMO was the most consistent indicator of lower quality care.

For-Profit HMOs Provide Lower Quality Care
Other Research Studies Reveal Lower Quality Care in For-Profits

Quality Indicator	For-Profit HMO (% of patients receiving service)	Not-For Profit HMO (% of patients receiving service)
Immunization of Toddlers	64%	72%
Mammography	69%	75%
Pap Smears	69%	77%
Diabetic Eye Care	35%	48%
Use of Life-Saving Beta Blockers	59%	71%

- ❒ A recent study concluded that ... "enrollment in an HMO or other managed care plan remained a highly significant predictor of lower quality ratings of doctors and over-all medical care and increased difficulties seeing specialists."[41]
- ❒ A study of over 3,600 patients with kidney problems found that for-profit ownership of dialysis facilities is associated with 30 percent higher mortality and 26 percent lower rates of placement on a renal transplant waiting list. The care of patients with kidney problems is a $15.6 billion industry.[42]
- ❒ If all American women were enrolled in for-profit HMOs instead of non-profits, 5,925 more would die from breast cancer due to their lower rates of mammography.[43]

Summary: Activity 1

1. The corporate take-over of health care has turned it into a huge money-making industry. The managed care industry's profits are expected to top $3 billion in 2000 – up 60 percent from 1999.
2. The blatant cost-cutting tactics used by HMOs and managed care, with the resulting decline in health care quality, reveal that the twin goals of "market return" and quality care are mutually exclusive. The drive for profits and patient's welfare can't mix.
3. The maintaining of managed care's corporate profits demands that patients pay the price in lower quality health care. The public and doctors are discovering that a system whose goal is profit-making can never truly take care of patients. The health care corporations will always shift costs from themselves onto patients.
4. The corporatization of health care results in a variety of profit-making tactics – for example, decreasing hospital services and stays, controlling the doctor-patient relationship, arbitrary denials and delays of coverage, downsizing staff, overworking staff, closing emergency rooms – to resist actually providing services to sick people. These profit-making tactics seriously compromise all our health.
5. Managed care is refusing to cover the elderly – who are viewed as too costly – as they maintain exorbitantly high pay and stock options for their executives. The private managed care system has rewarded health plans, through higher profits, that cherry-pick the healthy seniors and avoid the sick.
6. The private managed care system has skimmed off increasing amounts of our health care premiums in bloated administrative and marketing costs and profits. As much as one-third of our premium costs are going to support CEO compensation, marketing and profits.

(continued)

Summary: Activity 1

7. For-profit ownership of an HMO is the most consistent predictor of poorer quality care.
8. The public and the medical community is demanding change; workers are taking action. Eighty-two percent of doctors and patients are calling for fundamentally changing or completely rebuilding our entire health care system.
9. The corporatization of health care has a profound effect on our lives. Because private insurers have become corporations and health insurance is linked with our jobs, our employers have become gatekeepers to our health care and our employment can be undermined as our medical privacy is eroded.

Footnotes:

Activity 1: The Corporate Takeover of U.S. Health Care

1. Survey by the Kellogg Foundation as reported in *Physicians for a National Health Program Newsletter,* March 2000.
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6. The Henry J. Kaiser Family Foundation, "The Public, Managed Care and Consumer Protection," *Kaiser Public Opinion Update*, February 2000.
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8. Richard Blumenthal (Connecticut Attorney General), quoted in Paul Zielbauer, "Connecticut Sues HMOs Over Handling Patients," *New York Times*, September 8, 2000.
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11. Johanna Bennett, "HMO Sector Is Expected to Post Strong Results," *Wall Street Journal*, April 24, 2000.
12. Corporate Research Group, Inc., "Managed Care in the New Millennium," New Rochelle, New York: CRG: 2000. A company press release. Biz.yahoo.com/prnews/000207/ny-corpora-1.html.
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(continued)

Footnotes:

Activity 1: The Corporate Takeover of U.S. Health Care

15. Kevin Grumback, et al., "Primary Care Physicians' Experience of Financial Incentives in Managed Care Systems," *New England Journal of Medicine*, vol. 339, no. 21, November 19, 1989, p. 1516.
16. Survey by the Center for Studying Health System Change (an independent research group in Washington) in Jennifer Steinhauer, "Off the Managed-Care Treadmill," *New York Times*, July 2, 2000.
17. Jamie Court and Frances Smith, *Making a Killing: HMOs and the Threat to Your Health*, Monroe, ME: Common Courage Press, 1999, p. 29.
18. "ABMG Physician Status Report," October 1998 in Court and Smith, *Making a Killing*, p. 32.
19. Court and Smith, *Making a Killing*, p.6.
20. Richard A. Oppel, Jr., "New HMO Fight: Medical Discipline," *New York Times*, May 28, 2000.
21. Erik Larson, 'The Soul of an HMO," *Time*, January 22, 1996 cited in Court and Smith, *Making a Killing*, p. 52.
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23. *Oncology Issues 1997*, vol. 12, no. 5, p. 22, from Physicians for a National Health Program Slide Show, 1998.
24. Julie Appleby, "ER Conditions Crowded for Rescuers," *USA Today*, February 3, 2000.
25. Jean Fisher, "Full Emergency Rooms Send Ambulances in Circles," *The Sacramento Bee*, April 17, 2000.
26. Court and Smith, *Making a Killing*, p. 78.
27. Linda Kohn, Janet Corrigan and Molla Donaldson, eds., "To Err Is Human: Building a Safer Health System," Washington, D.C.: 1999, Executive Summary.
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(continued)

Footnotes:

Activity 1: The Corporate Takeover of U.S. Health Care

32. For a complete list, see "Medicare + Choice Plan Withdrawals," www.medicarehmo.com/mrepflrOl.htm.
33. "New Report Shows HMO Executives Receive Huge Compensation," News Release, June 21, 2001, www.familiesusa.org.
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35. "Not by the Numbers, Please," *Modern Healthcare*, May 8, 2000, p. 34.
36. George Anders and Laurie McGinley, "Medical Cop: Actuarial Firm Helps Decide Just How Long You Spend in the Hospital," *Wall Street Journal*, June 15, 1998.
37. BestWeek Life/Health Special Report, April 12, 1999 from SEC Filings, from Physicians for a National Health Program, Chicago, Illinois.
38. "TLPJ Files Class Action Against Kaiser Permanente for Forcing HMO Members to Split Pills," December 6, 2000, www.tlpj.org.
39. Phil Galewitz, "HMOs Cut Costs with Chopped Pills," Associated Press, Yahoo.com., March 22, 2000.
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42. Garg et al., *New England Journal of Medicine*, vol. 341, no. 22, pp. 1653-1660.
43. David Himmelstein, quoted in Anders and McGinley, "Medical Cop."

Activity 2

Health Care in the United States

Purpose: To get an overview of health care in the United States by comparing it with other countries and analyzing who has access to it.

There are two tasks in this Activity.

Task 1

In your small group please read the statement below. Does your group agree or disagree with it? Why or why not? Choose someone in your group to take notes on your discussion and to present it to the whole group.

Refer to Factsheets 1 through 7 when discussing the statement. Please complete Task 1 before moving on to Task 2.

Statement

"Sure, the United States' health care system has problems but we're still the best in the world. We spend a lot on health care but we get good care and good results. After all, you get what you pay for."

Task 2

In your small group please read the statement below. Does your group agree or disagree with it? Why or why not? Choose someone in your group to take notes on your discussion and to report it to the whole group.

Refer to Factsheets 8 through 17 when discussing the statement.

Statement

"In general, people in the United States get the health care they need – either from their jobs or from the government. Most of us get our health care coverage through our jobs. The poor, disabled and the elderly are taken care of by the government-run programs, Medicaid and Medicare."

Health Care Comparisons:
The United States and Other Countries

Factsheet 1

The United States Spends More on Health Care Than Any Other Major Industrialized Country

The United States spends more per person on health care than any other country – almost $4,500.[1] In the United States, spending on health has taken up more and more of our economy every year as measured by the Gross Domestic Product (GDP). In 1960, health care spending was 5.3 percent of GDP and today, at almost 13 percent, it has more than doubled.

Health Care Spending in Selected Industrialized Countries, 1998

Country	Amount Spent Per Person	Percent of Economy Spent on Health Care
Australia	$2,043	8.5%
Belgium	$2,081	8.8%
Canada	$2,312	9.5%
Denmark	$2,133	8.3%
Finland	$1,502	6.9%
France	$2,077	9.6%
Germany	$2,424	10.6%
Japan	$1,822	7.6%
Norway	$2,425	8.9%
Sweden	$1,746	8.4%
Switzerland	$2,794	10.4%
United Kingdom	$1,461	6.7%
United States (1999)	$4,443	12.8%

With all this money being spent on health care in the United States shouldn't we have great care? Don't you get what you pay for? The following factsheets will examine what we get compared with other countries which spend considerably less.

Factsheet 2

The Only Industrialized Country Without Universal Health Insurance

Despite the highest level of spending on health care, fewer people in the United States benefit from government-assured insurance coverage than people in any other major industrialized country. Today, 38.7 million people (14 percent of the population) in the United States have no health insurance.[2] Most countries instituted universal health coverage (at least 99 percent of the population) for their citizens between 1960 and 1997.

Health Insurance Coverage in 28 Countries

Of the 29 OECD nations, 26 have universal health coverage. Only the U.S., Turkey and Mexico do not. Each of the 26 use some form of national or single-payer plan, except Germany and the Netherlands which operate through a network of private insurance firms and public subsidies.[3]

Percent of Population with Government-guaranteed Health Insurance, 1997			
Australia	100%	Japan	100%
Austria	99%	Korea	100%
Belgium	99%	Luxembourg	100%
Canada	100%	Mexico	72%
Czech Republic	100%	Netherlands	72%
Denmark	100%	New Zealand	100%
Finland	100%	Norway	100%
France	99.5%	Poland	100%
Germany	92.2%	Portugal	100%
Greece	100%	Spain	99.8%
Hungary	99%	Sweden	100%
Iceland	100%	Switzerland	100%
Ireland	100%	Turkey	66%
Italy	100%	United Kingdom	100%
		United States	33.3%

Factsheet 3 U.S. Spends Most on Health – Citizens Don't Live to Enjoy It

Although the U.S. spends more on health care than any other country, it has the worst rate of infant mortality of all developed countries. And, we don't live as long as people in other industrialized countries.[4] Although measures such as life expectancy and infant mortality are recognized as crude indicators, they are used as proxies for health care outcomes of countries.

Life Expectancy and Infant Mortality

Country	Life Expectancy For Men, 1997	Life Expectancy For Women, 1997	Infant Mortality– Deaths in First Year of Life/1000 Live Births (2000 projection)[5]
Australia	75.6 years	81.3 years	5.0
Canada	75.8	81.4	5.4
Sweden	76.7	81.8	4.0
France	74.6	82.3	5.6
Germany	74.1	80.3	5.1
Japan	77.2	83.8	4.1
Norway	75.4	81.0	4.0
United Kingdom	74.3	79.5	5.7
United States	**73.6**	**79.4**	**6.7**

Factsheet 4

U.S. Men and Women Lose Valuable Years

Compared with other major industrialized countries, we die earlier from causes that could have been prevented. In the United States, for every 100,000 years of life, men lose 7,351 years from causes that could have been prevented. The rate for U.S. women is 4,213 years lost for every 100,000 life years.[6]

The Number of Years Before Age 70 People Died From Preventable Causes

(Number of Years Lost per 100,000 Life Years, 1997)

Country	Male	Female
Australia	5,429 years	3,032 years
Canada	5,215	3,069
Sweden	4,199	2,594
France	6,593	2,990
Germany	6,021	3,082
Japan	4,366	2,372
Norway	5,256	2,762
United Kingdom	5,319	3,302
United States	7,351	4,213

(continued)

Factsheet 4

A Good Public Health System Can Add Years to Lives

Even if you and your co-workers have a superb health plan and access to good medical care, your health can still be in jeopardy if the public health system is deficient. Public health measures – such as assuring that drinking water is safe, that sewage doesn't contaminate the water or food supply, that the air we breathe is clean and free of toxic chemicals, that lead paint is removed from houses where children live – are even more important than doctors and nurses in preventing illness and premature death. Public health departments also play a vital role in anti-smoking campaigns and in tracking diseases (like tuberculosis) so that we get early warnings of epidemics and can stop them from spreading. We spend only 3 percent of our health budget on public health, far below the 7 percent needed to do the job right.[7]

Factsheet 5

In the United States: Pay More, Get Less

As we've learned, the United States spends more on health care than other countries. Yet, U.S. residents are hustled out of hospitals and don't see doctors any more frequently than people in other countries. [8]

Average Hospital Stay and Number of Doctor Visits per Person

Country	Average Length of Stay – Number of Days per Person, 1996	Physicians Visits per Person, 1996
Australia	15.5 days	6.6
Canada	10.5 days	6.5
Denmark	7.3 days	5.4
France	11.2 days	6.5
Germany	14.3 days	6.4
Japan	43.7 days	15.8
Norway	9.9 days	NA
United Kingdom	9.8 days	5.9
United States	5.2 days (was 6.4 in 1990)[9]	6.0

Access to Health Care:
How Do People in the United States Get Health Coverage?

Factsheet 6

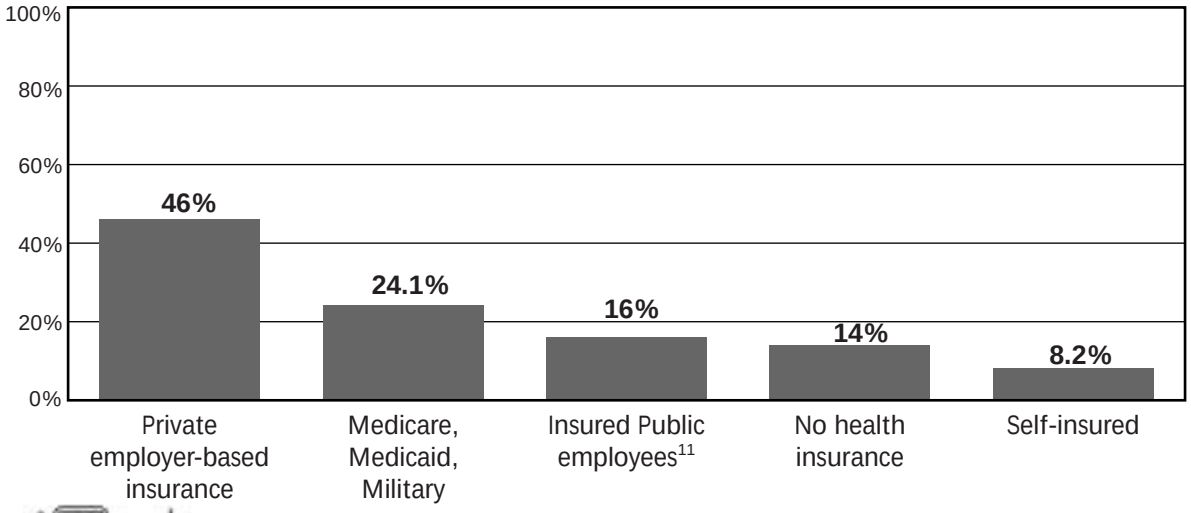
How People Get Their Health Insurance

Many think that most of us get our health insurance through our jobs, and that the government takes care of those without jobs and those who can't take care of themselves. But the role of employers and the government in providing health care has been exaggerated.

Less Than Half of Workers Have Health Insurance Paid for by Private Employers. The chart below shows that less than half (46 percent) of those who work in the private workforce (non-government workers) get their health insurance paid for by an employer. Furthermore, participation in employer-provided benefits varies by type of job, race, gender and income.

Government Health Programs for the Elderly, Poor, Disabled and the Military Cover Only 24 Percent of the Population. Excluding those who work in the public sector, government programs for the elderly, poor, disabled and the military cover only a little over 24 percent of the population, leaving over 16 percent of people in the United States without health insurance.[10]

How People Get Their Health Insurance Coverage*



*Total is greater than 100% because people are covered by more than one type of health insurance.

Factsheet 7 The Majority of the Uninsured Are Workers

You can have a job in the United States but not have health insurance. Today 39 million Americans have no health insurance. Most of the uninsured are workers and dependents of workers. [12]

Who are the uninsured?

- ❒ 56.2 percent worked during the year
- ❒ 13.9 percent are children
- ❒ 26.5 percent did not work during the year.

The uninsured are most likely to be:[13]

- ❒ Families with incomes under $25,000
- ❒ Employees of companies with fewer than 25 workers.
- ❒ Workers in retail stores, hotels, restaurants and other service industry jobs. Women and minorities tend to be over-represented in these low-paying jobs.
- ❒ The uninsured include:
  - ❒ 11.6 percent white non-Hispanic*
  - ❒ 34.3 percent Hispanic
  - ❒ 21.6 percent African-American
  - ❒ 20.9 percent Asian
  - ❒ 27.1 percent Native-American

*Hispanics may be of any race.

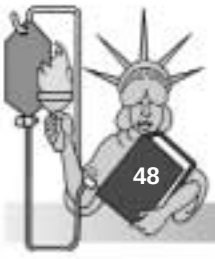
Factsheet 8 Many Workers Do Not Have Employer-Provided Health Insurance

We often assume that people who have a job automatically have health insurance. However, a large percentage of U.S. workers, particularly those in lower-wage jobs, are not enrolled in employer-provided health insurance.

The table below shows that almost half of the U.S. workforce – 47 percent – is employed in retail jobs and in health and business service jobs, which are among the lowest paying, on average. Workers in these jobs are the least likely to be enrolled in job-based health insurance – either because it doesn't exist, they are not eligible or decline to enroll.

Almost Half of the U.S. Workforce Is in Low-Paying Jobs; Most Workers in These Jobs Do Not Have Health Insurance[14]

Industry	Percent of All Workers Employed in These Jobs	Percent Enrolled In Employer-Provided Health Plan[15]	Average Yearly Salary
Retail Trade	**17.8%**	**34.3%**	$17,500
Health & Business Services	**29.8%**	**53.7%**	$25,680
Finance, Insurance, Real Estate	5.8%	67.9%	$28,120
Wholesale Trade	5.4%	67.2%	$28,020
Manufacturing	14.8%	78.3%	$26,980
Transportation, Communication, Public Utilities	5.2%	72.5%	$30,680
Construction	4.7%	42.4%	$33,900
Mining	.45%	82.1%	$33,900
Government	15.7%	87% (U.S. average for State workers)[16]	$33,156 (U.S. average for State workers)



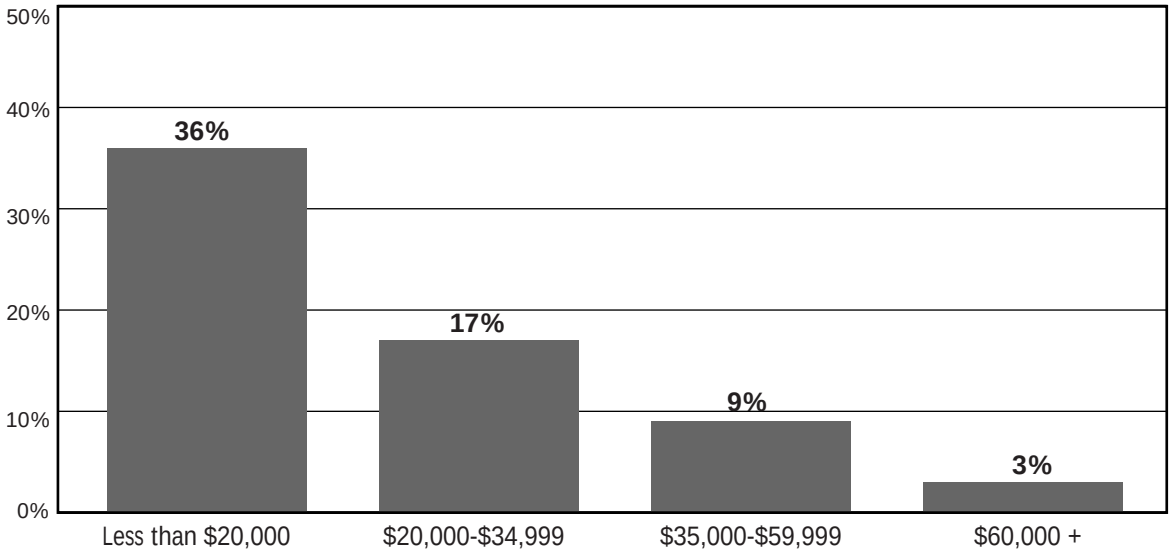
Factsheet 9

Many Full-Time Workers Can't Get Health Insurance

Working full-time is no guarantee that you and your family will have health insurance. Many of the uninsured do not have health insurance because they are in the lowest-paying jobs, which are the least likely to offer health insurance. As the table below shows, 53 percent of full-time workers with incomes under $35,000 per year don't have employer-based health coverage because it isn't offered or they are not eligible.[17] That's over 72 million people![18]

Percent of Full-time Workers Who Don't Have Employer-Sponsored Health Plans

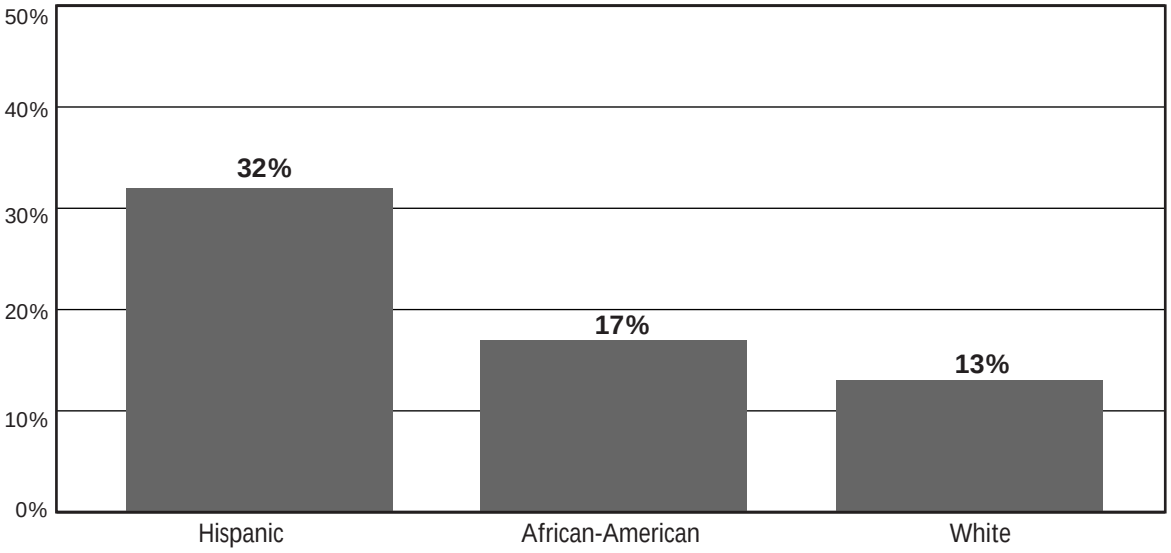
(By Income)



Factsheet 10 Full-time Jobs Don't Provide Health Protection Especially for Hispanic Workers

The lack of health insurance among full-time workers crosses all races. However, Hispanic workers tend to have jobs that are much less likely to offer employer-sponsored health benefits. Thus, over one third of full-time Hispanic workers are uninsured.

Percent of Full-Time Workers Who Are Uninsured
(By Race)[19]



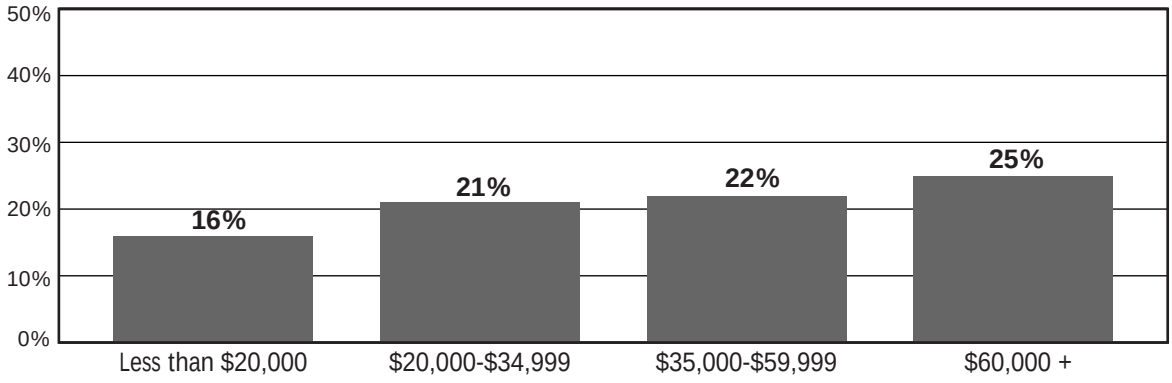
Factsheet 11 Health Care Coverage Is Too Expensive for Many Workers

With premiums increasing ten to 30 percent, more and more workers are forced to go without coverage because it is becoming too expensive.[20] The average annual group premium shared by employers and employees is around $2,650 for single coverage and $7,053 for family coverage.[21] Rising health care costs and a sputtering economy mean workers are going to pay the price.

As the Costs of Premiums Rise...

Percent of Adults with Employer-Based Coverage Who Pay $1,500 or More for Premiums[22]

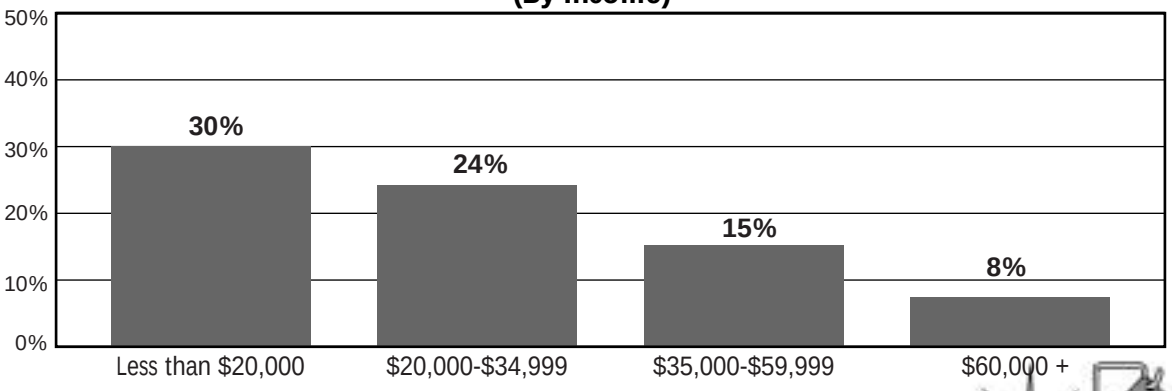
(By Income)



....Workers Have Difficulty Paying for Health Premiums

Percent of Insured Adults Who Have Difficulty Paying Their Premiums[23]

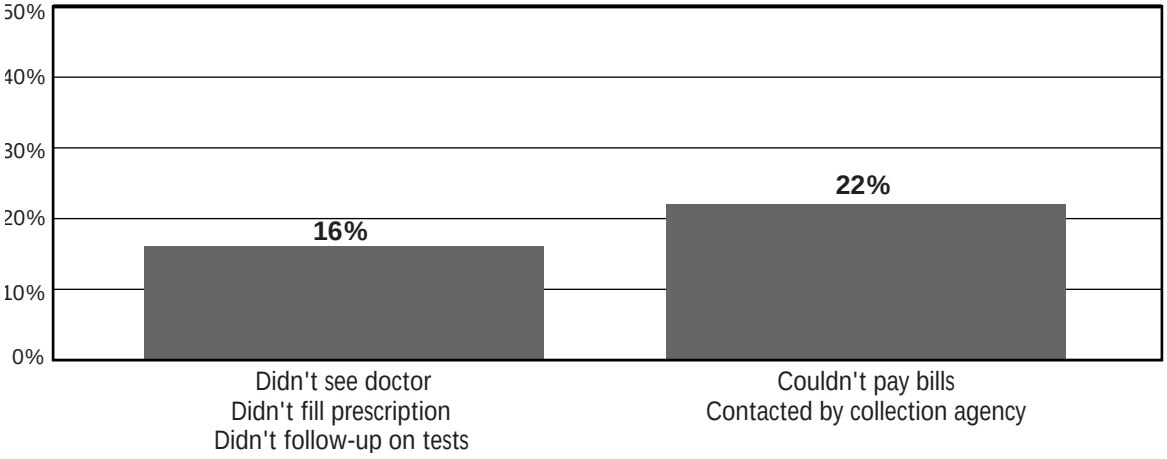
(By Income)



Factsheet 12 Workers With Coverage Forego Medical Care Due to Costs

It is not just the poor and uninsured who can't afford health insurance. Even working families with insurance can't afford medical care. One out of every four adults who have year-round, employer-based insurance reported not seeking medical treatment because of costs or having problems paying for medical care.[24]

Percent of Adults With Year-Round Employer-Based Coverage Who Did Not Seek Care or Had Bill Problems



But the greatest financial burden of health care falls disproportionately on poorer and middle class families. **Middle-income families spend twice the percentage of income, and the poorest families spend six times the percentage of income, that wealthier families spend on health care.**[25]

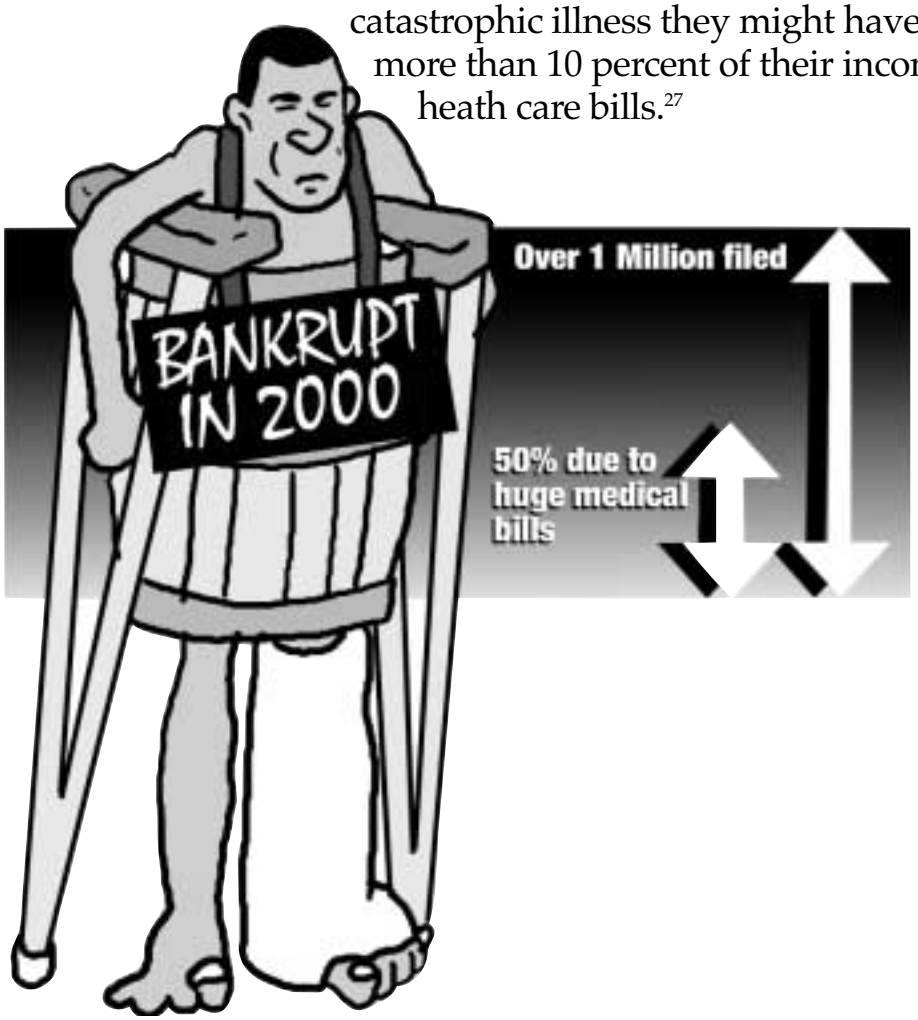
Family Income	Percent of income spent on health care
At least $100,000	3%
$45,000	6%
Under $10,000	17%

Factsheet 13 You Can Have Health Insurance but Be One Serious Illness Away From Financial Collapse

More than 1 million Americans filed for bankruptcy last year. In almost 50 percent of these bankruptcies, huge medical bills or other financial problems associated with illness or injury were partially to blame.[26]

The people who filed for bankruptcy were not the uninsured but middle class families who did not have enough insurance to cover catastrophic medical costs. While these people are dealing with serious illness or injury they also have to face losing their homes and debt collectors for the rest of their lives.

Behind the 42 million uninsured are 31 million Americans who have health insurance but are underinsured. This means that if they have a catastrophic illness they might have to spend more than 10 percent of their income on their heath care bills.[27]



Factsheet 14 Employer-Based Health Coverage = Employees Picking Up the Tab

Employer-based coverage doesn't mean what it used to. Payment for coverage has shifted from employer to employee. In 1983, 45.5 percent of policy holders had coverage paid in full by their employer. By 1998 the proportion had fallen to 26.6 percent.[28]

Health Coverage in Medium and Large Firms Declines[29]

	1991	1997
% of Employees in Medical Plan	83%	76%
% in Traditional Fee for Service	67%	27%
% Employer Paid Coverage	49%	31%

*100 or more employees in private firms, for full-time employees.

Health Coverage in Small Firms Declines*

	1990	1996
% of Employees in Medical Plan	69%	64%
% in Traditional Fee for Service	74%	36%
% Employer Paid Coverage	58%	48%

*Fewer than 100 employees in private firms, for full-time employees.

Factsheet 15 Employers Will Continue to Pass on Costs to Workers or Drop Health Insurance Altogether

In an effort to cut their costs even more, employers will continue to shift the burden of paying for health care on to their employees. In a recent national survey of 3,326 companies, two out of five employers plan to pass on more of the cost of health benefits to their employees.[30]

As the table below shows, employers are increasing the cost of premiums, raising co-payments and deductibles as well as reducing benefits (for example, offering either dental or disability but not both).[31]

How Employers Reduce Health Care Costs
(1999)

Private Sector	% Raising co-pay	% Raising premium costs	% Raising deductible	% Reducing benefits
For administrative, executive and professional employees *	18%	28%	14%	6%
For office workers **	13%	22%	10%	5%
For production and manual workers ^	17%	26%	13%	5%

*2,928 companies in survey
** 1,866 companies in survey. Data for 1998.
^ 2,227 companies in survey.

Some employers, particularly smaller companies, may stop offering health insurance altogether if the costs become too high. In a recent survey, one in seven businesses with fewer than 100 employees said they would drop health insurance if their premiums increased by 10 percent.[32]

Factsheet 16 Medicaid Program Not Serving the Poor

Medicaid, an income-based program for the poor and disabled, insures about 13 million poor people. **However, despite Medicaid, almost one-third of the poor (9.2 million people) have no type of health care.** Almost three-quarters of those receiving Medicaid are aged, blind or disabled. About 13 percent are children under 21 and only ten percent are adults in families with dependent children.[33]

Difficult to Get Medicaid . . . .

Many who qualify for Medicaid are not receiving it – often because individual states do not promote the program or make it very difficult for people to become enrolled.

For Children

For example, Texas has almost 600,000 children who qualify for Medicaid but who are not enrolled. This is because Texas has severe limits and very complicated eligibility rules that make it "one of the most difficult states for someone to figure out how to get enrolled," according to Diane Rowland, executive vice-president of the Henry J. Kaiser Family Foundation.[34]

For Working Parents

Most states impose strict limits on the amount of income a parent can earn and still qualify for Medicaid. In 32 states, parents who work full time at the minimum wage of $5.15 per hour are considered to have too much income to qualify for Medicaid. In Louisiana, Virginia and Texas parents working at minimum wage cannot get Medicaid if they work more than 12, 17 and 18 hours respectively.[35]

(continued)

Factsheet 16

A recent study found that nearly a million low-income parents (income under $28,300 for a family of three) lost Medicaid and probably have become uninsured since the overhaul of welfare in 1996. According to federal law, people leaving welfare can receive health insurance under Medicaid for six months to a year. However, many states have not carried out this law or made it widely known. Hundreds of thousands of families who were forced to leave welfare typically took low-waged jobs that do not offer health insurance or, if it is offered, the premiums are too expensive. These working families lost welfare and are now without health insurance because they lost Medicaid.[36]

Factsheet 17 Medicare Not Serving All the Elderly

Medicare is a social insurance program that serves those eligible by age, regardless of income or health problems. Medicare covers 39 million people who are elderly or disabled. Almost all persons 65 years of age and over are covered by Medicare.[37] However, because Medicare does not cover prescriptions, many of the elderly enrolled in Medicare HMOs, most of which provided drug coverage in addition to regular medical care. Subsequently, many HMOs started charging steep premiums for this coverage or pulled out of Medicare altogether. In spite of Medicare, with a median income of $20,761 (lower than the median income of those 15 – 24 years of age), many seniors are struggling to meet their health care needs.[38]

No Prescription Drug Coverage Under Medicare

Outpatient drug coverage is excluded from Medicare. Although about two-thirds of Medicare recipients have supplemental drug coverage, too often that coverage is very expensive, very limited and on the decline as HMOs continue to dump the elderly. Of the one-third of Medicare recipients who have no prescription coverage, almost one-fourth with incomes over $45,000 have no prescription coverage, contradicting the belief that lack of coverage is a problem only for the poor.[39]

As a whole, the elderly spend more on drugs than any other age group – they account for more than one-third of the nation's drug expenditures.[40] On average, Medicare beneficiaries spend about 19 percent of their yearly income on out-of-pocket expenses. The two million elderly who are poor but not covered by Medicaid spend about 54 percent of their income on out-of-pocket expenses.[41]

(continued)

Factsheet 17

Medicare HMOs Raising Premiums and Reducing Prescription Coverage

Average premiums are tripling from $64 to $190 a year. However, many seniors will face much larger increases. Aetna, in Connecticut, is raising premium costs for its Medicare HMO clients from $228 per year to $972 per year, and capping medication coverage at $500 per year. 32 percent of HMOs are limiting drug coverage to $500 per year or less and over 70 percent of HMOs are raising co-payments for drugs.[42]

Summary: Activity 2

1. The United States is the only industrialized country without universal health insurance.
2. The United States spends more on health care than any other major industrialized country yet does not have "better" outcomes in public health. Compared with other countries, the United States has the shortest number of hospital stays, one of the lowest number of physician visits per person, the lowest life expectancy for both men and women, and the highest rate of infant mortality.
3. The majority of working people do not get health insurance through their jobs. Only 46 percent of those who work in the private-sector get health insurance paid for by an employer. This lack of insurance is because, in part, so many workers are: in low paying jobs which tend not to have health insurance; are ineligible for job-based health insurance; or can't afford it.
4. Working full-time is no guarantee that you and your family will have health insurance. Fifty-three percent of full-time workers with incomes of $34,999 and less (over 72 million people) are not offered or are not eligible for health plans offered at their jobs.
5. Over one-third of full-time Hispanic workers are uninsured because the jobs they are able to get are the least likely to offer health insurance.
6. Many workers don't have health insurance because they cannot afford the premiums. About 37 percent of those with incomes of $34,999 and less pay $1,500 or more for their premiums.
7. Even workers who have health insurance through their work often don't seek medical treatment because of the high costs.

(continued)

Summary: Activity 2

8. Across the board, the number of employees in health insurance plans in small, medium and large firms has declined and employees are picking up more of the tab for their insurance premiums. Employers will continue to raise the cost of premiums, co-payments, and deductibles, reduce benefits, and possibly stop offering health coverage altogether.
9. Today there are 39 million uninsured Americans. The majority of the uninsured are workers and their dependents.
10. Despite Medicaid, the government program that is supposed to provide health insurance for the poor and disabled, almost one-third of the poor (10.4 million people) have no type of health care coverage. Many who qualify for Medicaid are not receiving it because states don't provide information about the program, or they make enrolling in the program too confusing, difficult and strict.
11. Although most of the elderly are covered by Medicare, many are struggling to meet their health care needs. Because Medicaid does not cover prescription drugs, the elderly – even those with supplemental private health insurance – are spending a high percentage of their incomes for medication (19 percent on average; 54 percent for the poor).

Footnotes:

Activity 2: Health Care in the United States

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15. U.S. National Center for Health Statistics, *Employer-Sponsored Health Insurance, State and National Estimates, 1997*, cited in U.S. Census Bureau, *Statistical Abstracts, 1999*, Table 188.
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(continued)

Footnotes:

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24. The Commonwealth Fund, *Listening to Workers*, Chart 18, p.30.
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Activity 3 The Canadian Health Care System: What Is It, How Does It Work?

Purpose: To become familiar with the Canadian health care system.

There are two tasks in this Activity.

The Canadian Health Care System

The Canadian Health Care System provides universal coverage for all its citizens – whether or not they have money or a job. This means that every Canadian is covered, from birth to death, for all medically necessary hospital, in-patient and out-patient physician services. Canadians present their medical card when receiving treatment and never fill out insurance forms or receive any bills. Canadians are free to choose their own doctors and hospitals. The national program is funded through general tax revenues. The government administers the not-for-profit program. Private doctors and non-profit hospitals provide services.

The Canadian health system is suffering from budget cuts as health needs are changing. Canada's system assures national coverage for all hospital care and physician services – the type of care that was available in the 1960s when the program was initiated. Since then, other kinds of health care have become increasingly important – outpatient drugs, home care – and these are not fully covered.

Despite the problems, Canadians are fiercely loyal to their health care system and are fighting to improve it. Although the Canadian system is not perfect, it provides quality care to all for a fraction of what the U.S. spends. Relative to Americans, Canadians have a firm health care base from which to fight for even better care. Their system deserves our investigation.

Task 1

Please complete Task 1 before moving on to Task 2.

The facilitator, or someone from the group, will read out loud the three paragraphs about the Canadian health care system on the previous page. (Factsheet 1 presents more details about the Canadian system).

Then, in your small groups read the statement below and discuss it. Do you agree or disagree with it? Why or why not?

Remember to choose one person to record your discussion for the report-back to the whole group.

Statement

(Refer to Factsheets 1 through 8.)

The Canadian health care system has a lot of problems. They don't have sufficient high technology, so people have to wait a long time for medical care. Prescription drugs are more expensive in Canada, and Canadians have little control over their medical decisions. In general, health care in Canada is inferior to that in the United States.

Task 2

In your small group read the following statement and then discuss it. Do you agree or disagree with it? Why or why not? Remember to choose someone to take notes and to present your group's discussion.

Statement

(Refer to Factsheets 9 through 14.)

Canadians suffer from a big, government-run health care system that requires a large bureaucracy. Canadian citizens have to pay a lot of taxes to support it. Although Canadians don't have to pay any fees when they go to a hospital or doctor – they just have to present their health card – the door for abuse of health care is opened. You get what you pay for. People value more the things they have to pay for. All in all, the Canadian health care system is socialized medicine, and it's just not right for the United States.

Factsheet 1

Canada's National Health Program

Below is a brief summary of the current Canadian health program.[1] The factsheets that follow provide more information about the plan.

Canada's National Health Program

- In Canada, health care is a right. The Canadian health system is publicly funded through tax revenues (personal and corporate income taxes) and available to all. Every Canadian citizen is covered from birth until death for all medically necessary hospital, in-patient and out-patient physician services.
- Everyone is free to choose his/her own doctors and hospitals. Canadians merely present their health card to their provider and never receive a bill, never fill out an insurance form. There are no deductibles, co-payments or dollar-limits on services.
- 90 percent of Canadian physicians are in private practice. They operate under a fee-for-service payment system and they are free to practice where they choose. Over 95 percent of hospitals are private non-profits. They are accountable to the communities they serve, not to governmental bureaucracies.
- Medical fees are negotiated between the provincial governments and professional organizations representing doctors. Physicians control 80 percent of health expenditures by defining what is and isn't health care. Doctors and hospitals cannot charge extra fees for anything covered by the public insurance.
- All provinces except one provide universal drug coverage for the elderly with some user fees. Four provinces have universal drug plans for all with some co-payments and deductibles.
- Coverage of services like long term care, dental services, prescription drugs and eyeglasses varies by province, but usually are covered by private insurance. The majority of Canadians have supplemental private insurance.

(continued)

- ❒ Private insurance can only cover costs of services not provided by the national health plan.
- ❒ In most cases, the national health program also covers care in nursing homes, home care, and ambulatory care. Some provinces cover midwife services. Some provinces cover psychological services, chiropractic treatment and massage therapy, but usually with a co-payment.

The planning, financing, delivery and evaluation of services is the responsibility of each of the ten provinces and three territories. The federal government establishes and administers the national standards or principles for all of Canada's health care services. Transfer of federal funds to provinces and territories is dependent on adherence to the principles below.

The plan is based on five principles:

1. **Public administration:** The government pays for services out of taxes, but does not provide care. The program is publicly administered on a non-profit basis by a public authority accountable to the provincial government.
2. **Comprehensiveness**: All necessary services, as determined by one's physician, including drugs dispensed in hospital, are covered.
3. **Universality:** The plan must entitle 100 percent of the insured population (eligible residents) to services on uniform terms and conditions.
4. **Portability:** You take it with you, from job to job, province to province. Workers don't lose their health insurance when they change jobs or move to another province.
5. **Accessibility:** No economic or geographic limitations; rich and poor choose the same doctors and hospitals. No discrimination based on income, age, health status, etc.

Factsheet 2 A Brief History of Canada's National Health Program[4]

This brief summary demonstrates that major social change in the delivery of health care can occur very rapidly.

1. In the early 1900s, Tommy Douglas, a poor, young Scottish immigrant in Canada was treated in a charity ward. He faced amputation of an infected leg. By chance, an orthopedic surgeon intervened and performed surgery that saved the leg.
2. In 1944, Tommy Douglas became premier of Saskatchewan. He never forgot the medical service he, a poor boy, received by luck.
3. In 1947, he introduced North America's first universal in-patient hospital coverage for all citizens in Saskatchewan. The Saskatchewan government paid the major costs from general tax revenues with citizens paying small premiums. The program was a success. Douglas was reelected in 1948.
4. The Saskatchewan health care model caught on and many provinces initiated similar programs.
5. In 1957, all three federal political parties, usually at odds with each other, unanimously supported national hospital insurance. The federal government paid half the costs with the provinces paying the rest. There was much opposition from many hospitals, insurance companies and doctors.
6. By 1961, almost all Canadians were covered by publicly-supported hospital insurance (plans varied by province).
7. Also in 1961, Tommy Douglas initiated universal medical insurance in Saskatchewan, which was supported widely by the citizens. However, doctors went on strike and insurance companies launched an all out offensive against the plan.[5] But, universal medical care was voted in, due to immense public support.
8. A task force initiated by doctors themselves several years earlier, the Royal Commission on Health Services, recommended to the federal government, universal medical coverage throughout Canada, based on the Saskatchewan model. They concluded that this health scheme was the most efficient and effective as well as the most popular. Surprisingly, the conservative federal government supported it.

(continued)

9. Once again insurance companies organized an all out assault that played on doctor's fears of control by government and socialized medicine. Insurance companies wanted an open market for themselves based on multiple companies offering many voluntary plans.
10. Labor, which in Canada represents about 90 percent of all workers, supported the health plan and was crucial in securing it. Labor saw health care as a public service – one that put people's interests before insurance companies.
11. Employers did not campaign against the plan because they were experiencing the expenses of negotiated private insurance health benefits. For example, Chrysler calculated that in 1988, health benefits cost the company $700 U.S. per car in the United States, compared with $233 U.S. per car in Canada.[6]
12. The Medical Care Act of 1966 stated that all citizens have access to necessary medical care regardless of income or any other conditions. The federal government offered to pay half the costs each province incurred for health services.
13. By 1970 every Canadian was covered. Plans differed by province. Overall, doctors' resistance diminished when they saw how well the plan worked. However, some doctors billed extra for services. This practice grew and threatened the foundations of the public plan. The Canadian government aggressively wanted to put a stop to this "extra billing" practice.
14. In 1984 the Canadian Health Act was passed. This Act included penalties for "extra billing" as well as a new plan to finance the health system in response to rising costs. The federal government would transfer a lump sum of money to each province each year, instead of paying half the bills. In turn, the provinces would have the right to tax revenues that had belonged to the federal government. This Act remains in place today.

Factsheet 3

Canadians Get Quality Medical Care

Canada spends less on health care (9 percent of their economy) than the United States (14 percent of the economy), yet provides all its citizens with high quality medical care.[7]

1. Canadians Get More Doctor Visits

Average Number of Physician Visits per Person, 1996

Canada	6.5 visits per person
United States	6 visits per person

2. Canadians Get More Hospital Days[8]

Average Length of Stays in Hospital, 1996

Canada	12.2 days
United States	8 days

3. Canadians Lose Fewer Years of Life[9]

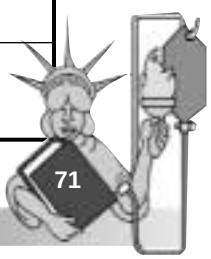
Potential Years of Life Lost per 100,00 Life Years from Preventable Causes, 1995

Canada	3,284 yrs. for women	5,451 yrs. for men
United States	4,591 yrs. for women	8,401 yrs. for men

4. Canadians Have Fewer Difficulties Affording Care

Difficulties Affording Care[10]

	U.S.	Canada
Problems Paying Bills	18%	5%
Couldn't buy prescription	17%	7%
Spent more than $750 out-of-pocket	29%	9%



Factsheet 4

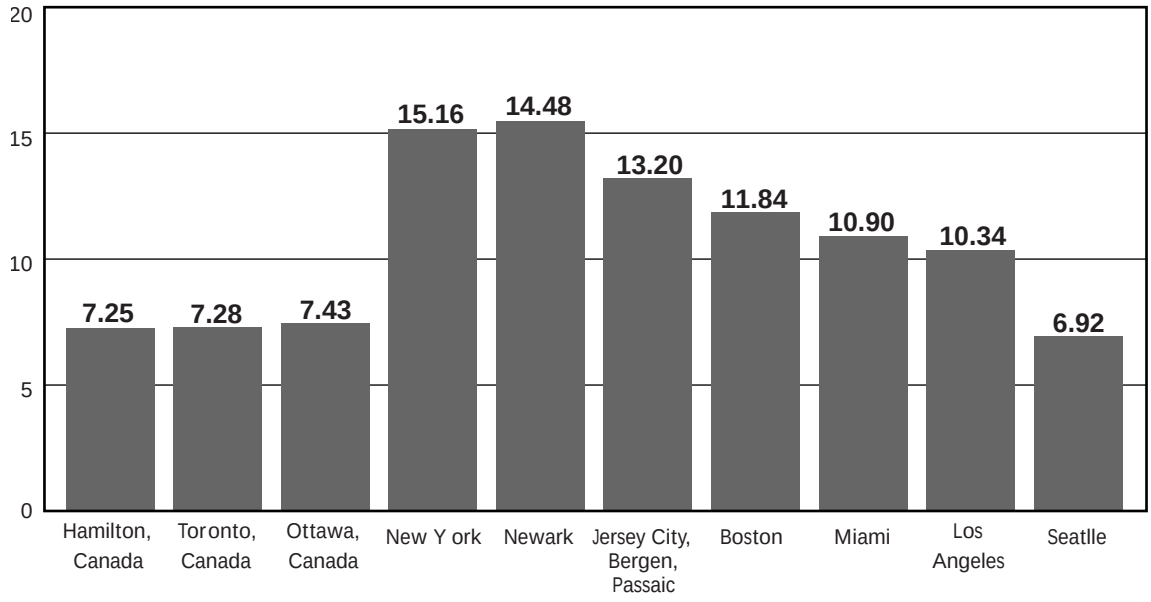
Access to Care Prevents Hospitalization

Because all Canadians have access to free health care, there are no barriers to visiting a doctor when symptoms first appear. Such access prevents more long-term care and lengthy hospital stays.

The graph below shows the rates of hospitalization for conditions that are usually preventable with good outpatient care — like asthma. The graph shows that Canadian cities had lower rates of such hospitalizations than most U.S. cities.[11]

Hospital Admissions For Conditions That Are Usually Preventable With Good Outpatient Care

(Admission rate per 1000 non-elderly people)



Factsheet 5 Canadians' Access to Specialists: Similar to Americans

Some would like us to believe that Canadians have difficulty seeing specialists and therefore don't get the medical care they need. However, as the table below shows, Canadians' access to specialists is somewhat better than Americans'.[12]

Access to Specialists: Canada and the United States

(Percent who reported in 1998 Commonwealth Fund Survey)

Statement	Canada	United States
There was a time in the past 12 months when I needed medical care but did not get it.	10%	14%
Extremely difficult to see specialists and consultants.	6%	9%
Not too difficult or not at all difficult to see specialist and consultants.	47%	56%

It is true that the United States has more specialists than Canada. The ratio of specialists to general practitioners in Canada is approximately the reverse of that in the United States. [60] percent of American doctors are specialists, while 51 percent of Canadian doctors are generalists.[13] But what good are specialists if you can't see them – as is the usual case in the U.S. for those with no insurance and even those with insurance that has many restrictions.

As we have seen in the previous factsheets, Canadian quality of care is better or comparable to that in the United States. While specialists and advanced technology are important, the need for expensive medical services can be reduced by providing preventive and primary care.

Factsheet 6 High-Technology Does Not Mean Better Care

The United States has four times as many MRI and cat scan machines for every one million people.[14] But more technology does not necessarily mean better care. A country's quality of care cannot be measured by the number and types of machines and high-tech procedures used. Hospitals, doctors, and equipment vendors may desire such technology merely because it brings more money and prestige, not because it provides better care for all citizens.

More Technology Does Not Mean Fewer Deaths

One study compared the death rates of patients with end-stage kidney disease treated in Manitoba, Canada and a random sample of U.S. patients.[15] The results:

- ❒ Manitoba patients were more than twice as likely to receive kidney transplants as U.S. patients.
- ❒ No Manitoba patients used dialyzers which had been used before and were reprocessed; 57 percent of U.S. patients did.
- ❒ The mortality rate was 47 percent higher in the United States.

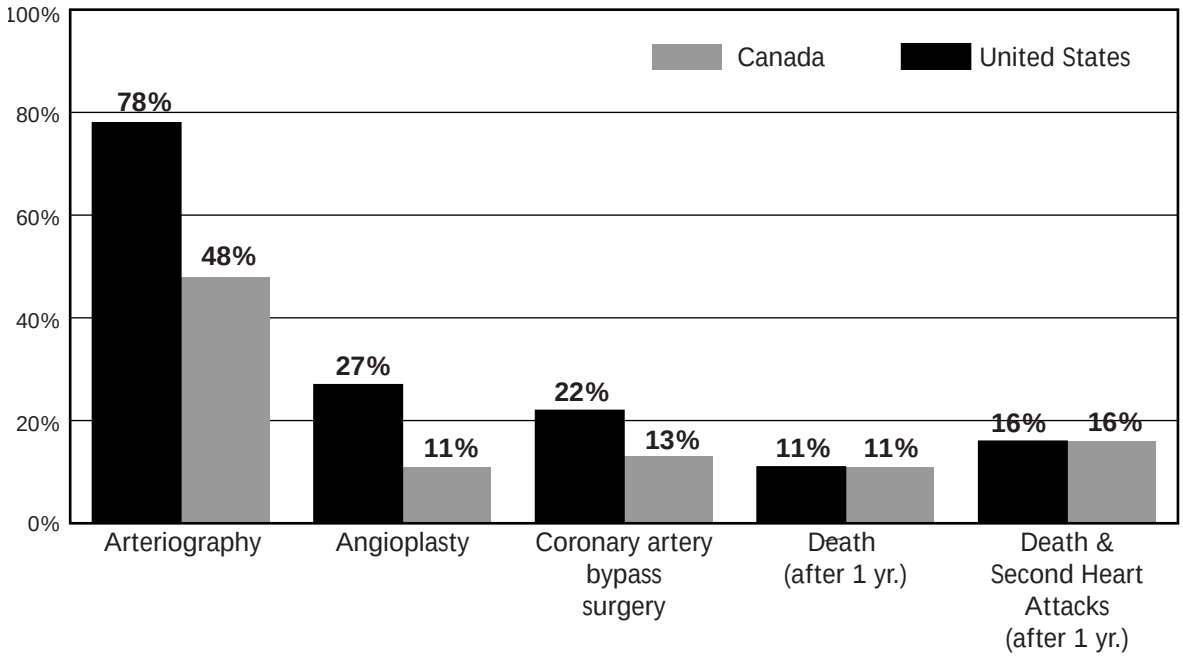
(continued)

Factsheet 6

More Surgery Does Not Mean Better Care

Another study revealed that the more invasive cardiac treatment in the United States did not reduce the likelihood for second heart attacks and death. As the graph below shows, while U.S. patients were more than twice as likely to have cardiac catheterization and coronary artery bypass surgery, and more than twice as likely to undergo angioplasty, they had death rates and second heart attack rates identical to those in Canada. [16]

More Invasive Heart Attack Treatment in U.S. Than in Canada, but Death and Second Heart Attack Rates Equal



Factsheet 7 Canadians Have Better Drug Coverage

Prescription drugs in Canada are free if they are administered in the hospital. Most Canadian provinces provide universal drug coverage for the elderly, poor and disabled with user fees in some cases. Some provinces – British Columbia, Saskatchewan, Manitoba and Quebec (in progress) – have universal drug plans, with user fees.[17] In the United States, one-third of the elderly lack any drug coverage.

Canadians Pay Less for Many Drugs (in $U.S.)[18]

Country	Risperidone (60, 3 mg tabs)	Prozac (30, 20 mg tabs)	Zantac (100, 150 mg tabs)
France	$124	$28	NA
Netherlands	$134	$35	NA
Canada	**$136**	**$38**	**$81**
Spain	$142	$26	NA
Italy	$148	$33	$77
Germany	$163	$52	$149
Sweden	$169	$39	NA
U.K.	$190	$34	$73
U.S.	**$248**	**$72**	**$169**

U.S. Seniors Pay More for Ten Top Selling Drugs*

(Average of Retail Prices for One Month Prescription in $U.S.)

Mexico	$9.35
Canada	$75.54
Vermont	$129.33

* Zocor, Ticlid, Prilosec, Relafen, Procardia XL, Zoloft, Vasotec, Norvasc, Fosamax, Cardizem CD.

(continued)

Factsheet 7

Why Are Prescription Drugs Cheaper in Canada?

- **In Canada (and Europe), drug advertising aimed at the public is not allowed.** Contrast this to the United States. Patients and physicians in the U.S. are bombarded with advertising from the pharmaceutical industry which drives up the demand for more and new drugs, enabling the companies to raise prices and increase their profits. The pharmaceutical companies spent $13.9 billion in 1999 to market drugs (over 50 percent more than they spent in 1996) and about $75 million every year to lobby members of Congress to pass laws favorable to the industry. The total sales from prescription drugs increased from $50 billion in 1993 to $100 billion in 1999.[19]
- **A revised Patent Act in Canada** allows licensed manufacturers to reproduce patented medicine upon paying royalties to the patent holder. Compare this to the United States, where drug companies hold patents for 20 years, courtesy of our Congress, guaranteeing their profits at our expense. For example, Abbott Laboratories secured a patent on Hytrin, a drug for high blood pressure and prostate enlargement. In order to secure their $500-million-a-year drug they secretively offered $2- to $4.5-million a month to companies wanting to make generic copies when the patent ran out. Abbott also filed for several secondary patents on components of the drug and filed lawsuits against generic drug companies just to buy time to make more profit. Some drug companies patent the color of their pills, the shape of their bottles, and method of delivery in order to secure their huge profits.[20]
- **The United States is the only country that does not have price controls on prescription drugs.** Other governments, like Canada, Japan and France control drug price; England controls the profits of drug companies. In the U.S., health plans, the government and individuals all pay different prices for the same drug, depending on their power in the marketplace.

(continued)

Factsheet 7

- **Canadian hospitals band together to buy drugs in bulk, thus reducing the cost of drugs.** This response is more likely to develop in a publicly run health care system where hospitals are not competing with each other for patients in order to increase their profits.

How U.S. Citizens Get Cheaper Canadian Prescription Drugs[21]

- Many elderly make trips to Canada, individually or in chartered buses, just to buy their prescriptions.
- Maine, New Hampshire and Vermont are forming a buying co-op to bring cheaper drugs to their elderly.
- Some U.S. doctors in states bordering Canada have obtained licenses to write out prescriptions directly to Canadian pharmacies.
- Some Vermont doctors fax drug orders for patients to a Canadian pharmacy. The drugs are then shipped to the doctor's office, where the patient can pick them up.
- Over one hundred physicians have assisted in setting up a Web site to help doctors obtain drugs for their patients from Canada.
- The U.S. pharmaceutical industry is responding with a major advertising campaign extolling the "failures" of the Canadian health care system.[22]

Facr Sheet 8 Canadians Health Not Compromised by Waiting Times

Those opposed to national health insurance say that Canadians' health is compromised because they have to wait longer for care than do Americans. Although there are differences in waiting times for some kinds of non-emergency surgeries, Canadians do not wait for care that is urgent and required immediately.

Waiting Times for Non-Emergency Surgery[23]

	Canada	United States
No waiting time	16%	10%
Less than one month	28%	60%
1 – 3.9 month wait	43%	28%
4 months or more	12%	1%

- There is little difference in patient satisfaction with their waiting time for general surgery between Canadians (84 percent) and Americans (85 percent). [24]
- Although Canadians waited longer for knee replacement surgery than Americans, only 5 percent felt this time was unacceptable. [25]
- Some Canadians, as do some Americans, choose to be on a waiting list because they prefer a particular doctor. Waiting periods are common to any system in which patients have unlimited choice of medical providers. Canadians have complete freedom to choose and change their doctors.

(continued)

Factsheet 8

- In all countries, health care is rationed one way or another. The Canadians choose to allocate a certain amount of money and resources for their health care without compromising anyone's life. The United States makes people wait – but in a different way. In the United States, access to health care, and to high-tech care, is rationed according to one's ability to pay. Only those with good insurance or the ability to pay get to see the best specialists. If you can't pay for it, you don't even get the chance to wait for it.
- Increased waiting times are one of the problems attributed to the budget cutting by the conservatives in the Canadian government who are starving the health care system of cash.

Are Canadians Coming to the U.S. for Treatment? No.

Some Canadians do come to the United states for medical care. And, some provincial health plans have negotiated contracts for specialized services with nearby U.S. hospitals. But these numbers are small. A research organization, Statistics Canada, surveyed Canadians on this issue. In their survey of several thousand Canadians, too few reported coming to the U.S. to be statistically significant. However, thousands of Americans go to Canada each year for medical care because it is less expensive.[26]

Are Canadian Doctors Leaving Canada? No.

The number of Canadian physicians moving abroad hit a five year low in 1999. In that year, 585 physicians left the country, while 343 moved back to Canada from the U.S. and other countries.[27]

Factsheet 9 Where Does the Money Come from? From Progressive Taxation and Government Subsidies.

It seems that universal health care for all Canadians must be extremely expensive. How do they do it?

Progressive taxation

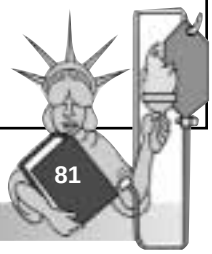
Canada's health care is largely tax-funded and their tax system takes a larger share of income from the wealthy than from the poor. Unlike the wealthy in the United States, wealthier Canadians pay a larger share of their income for health care than the less wealthy.

Government Subsidies

Government financing of the Canadian Health Program has gone through successive steps. When the Health Plan was first initiated, the Canadian federal government paid half of each province's health care costs. Then in 1977, provinces received some cash and some tax relief so that provinces could raise more of their own money. Today, federal contributions are tied to population and the economic conditions in each province, and the provinces pay the rest. The cash portion of the money the federal government transfers to the provinces has been reduced annually. Provinces now receive one payment (a block grant) to cover a variety of social service programs, including health care.

Canadian Health System Under Attack

There are many conservative "budget-slashers" in the Canadian government who would like to reduce the health care monies even more, cut back on services and increase the privatization of health care. Private insurance companies and private health care firms in search of profits (in Canada and the U.S.), some doctors wanting to increase their incomes, and some of the wealthy who would like to pay less taxes, support increasing privatization of their health care system. The push for "Americanization" of their health system is not coming from the majority of Canadian citizens. While many Canadians want to improve their system and change what's wrong with it, they are fighting to keep it in place.[28]

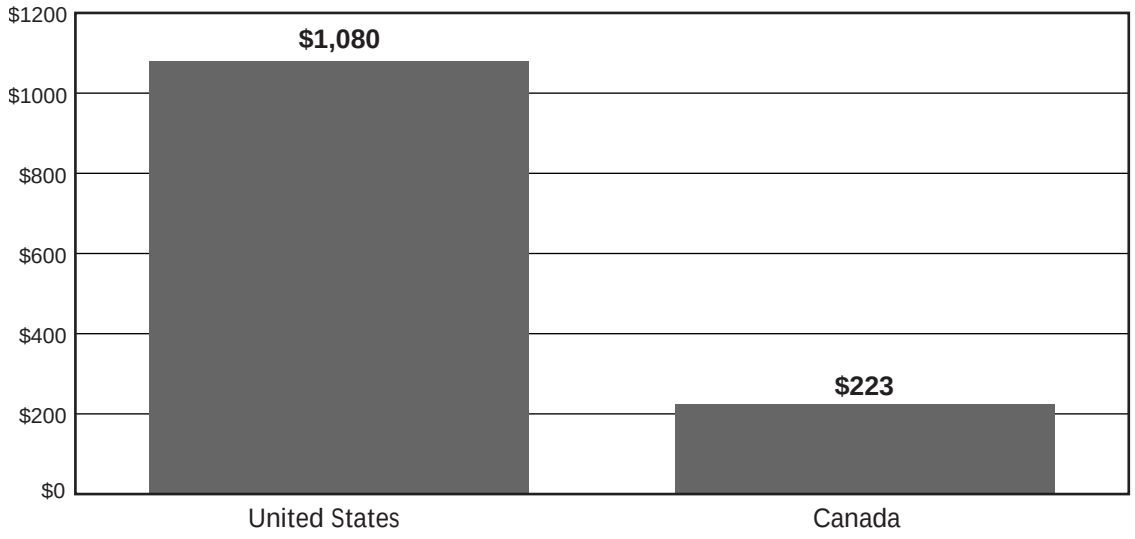


Factsheet 10 Where Does the Money Come From? From Money Saved from Public Administration

The United States spends about two-thirds more on health care than Canada, yet, Canada guarantees care to all. One of the main reasons for this disparity is the enormous administrative costs of the private, profit-driven health care sector in the United States. In the U.S., every hospital, every doctor's office, every clinic has its own administrative bureaucracy. Canadian doctors and hospitals do not need to keep detailed financial accounts for each patient, send them bills, determine who is or isn't eligible for Medicaid or deal with numerous insurance companies. Doctors can spend more time providing care to their patients rather than discussing the costs of a procedure and whether or not their insurance will cover it.

As the graph below shows, in 2000, it is estimated that the U.S. spent about $1,080 per person on maintaining the health care bureaucracy. Canada spent a little less than one-fifth this amount. [29]

Overall Administrative Costs, U.S. and Canada, 2000



(continued)

Factsheet 10

Because Canadians combine public administration with universal health care, they can simplify their administrative process. Compare this to the U.S., where the problems of health care are resulting in more laws, requiring more bureaucracy. According to the United States' National Conference of State Legislatures, health care issues made up a greater proportion of bills in states than any other topic in 1999 – about 27,000 out of about 140,000 bills, of which 1,400 became laws. By January 2000, over 16,000 health care proposals were already on the table.[30]

Canadian Hospitals

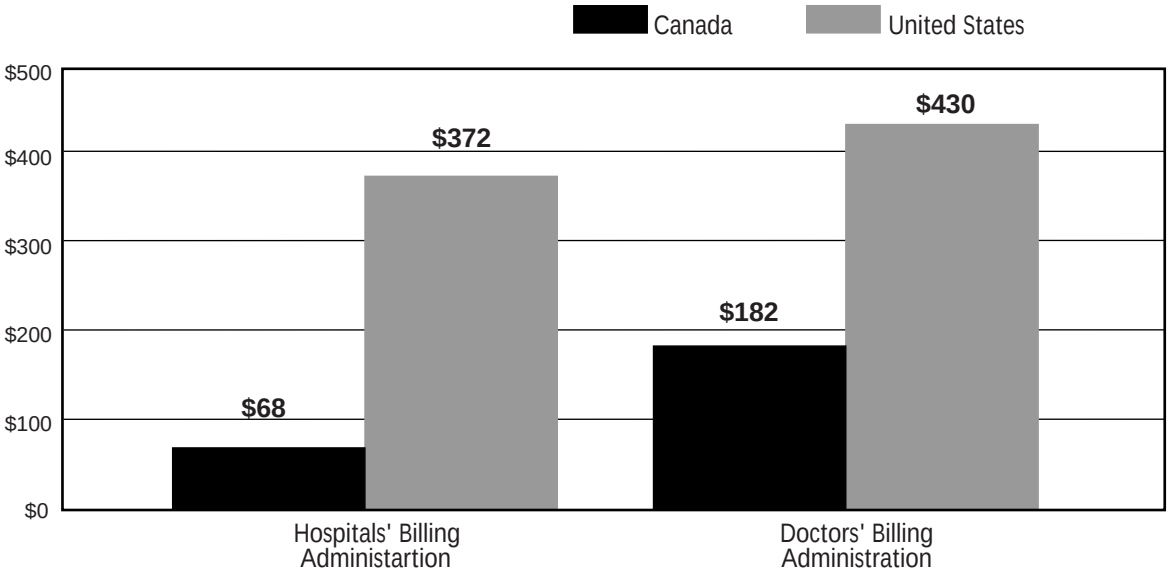
In a single payer system, office administration and billing is greatly reduced. Hospitals are paid a negotiated lump sum several times each year. Hospitals don't need huge administrative departments to track every service, determine insurance eligibility and to send out bills. Doctors likewise have simple billing procedures, unencumbered by the requirements of many different insurance companies. The public health insurance in Canada covers all aspects of care – in the hospital and in doctor's offices, all the equipment, supplies and personnel necessary for tests, all housekeeping services, and food and transportation services, as well as any physical therapy.

(continued)

Factsheet 10

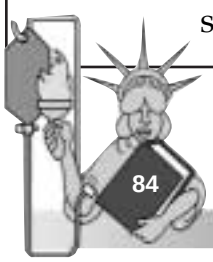
Canadian Hospitals and Doctors Spend Less on Billing and Administration[31]

(Dollars per Person)



A Comparison of U.S. and Canadian Hospital Experience

Larry, the husband of Judy Haiven, a Canadian journalist, had a heart attack after being admitted to the hospital for observation. He was in the hospital for several days, during which time he received monitoring in the cardiac unit, blood work, x-rays, ultrasound, angiogram, exercise stress test, an EKG and other tests. After he went home he enrolled in a cardiac rehabilitation program and was prescribed medication. He received no bills for any of these services and he and his family did not have to hassle with any insurance companies. Soon after, Judy and her husband traveled to California where Larry was admitted to a hospital for chest pains. A clerk demanded payment before admission. Larry received virtually the same treatment in California that he did in Canada. However, the total bill came to $12,590, including charges for sample-sized toothpaste, aspirin and a laxative he never took.[32]

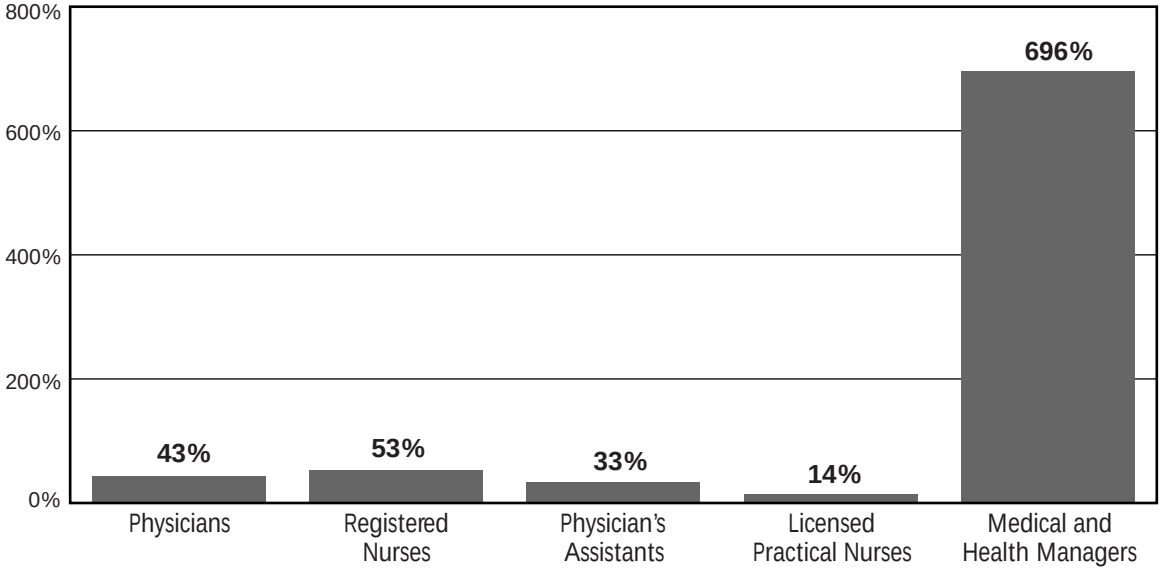


Factsheet 11 U.S. Bureaucracy Grows at the Expense of Doctors and Nurses

With the need for more and more bureaucracy in the U.S. health care system, the number of administrators has grown at the expense of skilled health professionals.[33]

Paper Pushing Jobs Grow at the Expense of Skilled Health Professionals

(Percent Increase in Occupation from 1983 to 1998)



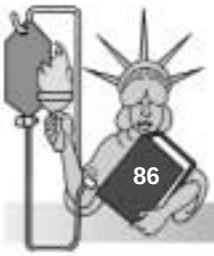
Factsheet 12 Do Canadians Abuse the System Because It Is Free?

- ❒ It isn't "free." Canadians pay for their health care through their progressively structured income tax – the wealthy pay a higher share of their income while the poor pay less.
- ❒ Although Canadians make the initial appointment with their doctor, their doctor determines what the subsequent, medically necessary, treatment will be. Patients cannot simply walk into a doctor's office or hospital and say they want a heart transplant or a nose job. And, unlike in the United States, Canadian doctors do not receive "bonuses" from insurance companies for keeping their costs down by denying various expensive services.
- ❒ In the United States, charging fees means that, too often, lower-income or poor people put off seeking medical care until their condition is serious, thus adding to long-care costs and the overuse of emergency facilities.
- ❒ Because everyone uses the same health care system in Canada, they share a common interest in making it the best possible system for everyone. Once you let the wealthier skip to the front of the line the pressure is lessened to maintain the system for everyone.

Universal Health Care Encourages Appropriate and Timely Use[35]

Survival rate of poor women in Toronto compared with poor Detroit women:

Breast cancer:	30% higher survival rate in Toronto
Ovarian cancer:	38% higher survival rate in Toronto
Cervical cancer:	48% higher survival rate in Toronto
Lung, stomach & pancreatic cancer:	50% higher survival rate in Toronto



Factsheet 13 The Canadian System Is Not Socialized Medicine

- ❒ Socialized medicine means doctors are on salary and employed by the government. But Canadian doctors are not on salary. The fees they charge are not set by the government but by negotiations between physicians' professional organizations and provincial governments.
- ❒ The Canadian government pays for services but does not provide care. The government merely provides a mechanism for financing the delivery of health care that eliminates the profit-making and administrative costs associated with private insurance.
- ❒ Doctors are free to practice where they wish.
- ❒ Individuals are free to choose any physician and any hospital.
- ❒ Every capitalist country in the world, except the United States, provides national health care. Promoting health care as a basic human right is not an indication of socialism. Providing health care for all is as important a social responsibility as providing fire and police protection.
- ❒ In the United States we've "socialized" essential services such as our retirement income support (Social Security), police protection, fire departments, and the military. This means that we view these services as essential for the common good – protected from competing services. The Canadian National Health Care System is similar in that it has "socialized" another essential service – health care — by providing public health insurance for all.

Summary: Activity 3

1. The Canadian system isn't perfect. But it gives us a picture of a possible alternative health care system that provides excellent health care to all citizens. The Canadian system is constantly evolving; ours should be too.
2. More and more Americans – doctors as well as the public – are becoming disenchanted with our profit-based health care system and are becoming more willing to explore alternatives. The health care corporations, lobbyists, drug companies, medical associations – all those profiting from our current health care system – are doing whatever they can to hinder this exploration. It is important for all of us to become familiar with the Canadian health care system so that we can judge for ourselves how it can be adapted in the United States.
3. In Canada all citizens are entitled to medical care without financial barriers. Because many Americans can't imagine health care as a right, a view perpetuated by the health care industry, Americans interpret problems in other countries' health care systems as proof that a national health program can't work.
4. Canada spends less on health care (9% of their economy) than does the U.S. (14% of the economy), yet Canadians get more doctors visits, more hospital days, enjoy a longer life and more affordable care than U.S. citizens.
5. Many studies show that Canadians' health care surpasses or measures up to that obtainable in the U.S. For example, one study showed that Canadian cities had lower rates of hospitalization than U.S. cities for conditions that are usually preventable with good outpatient care.
6. Canadian access to specialists is similar to or better than American access. While specialists are important, the need for expensive medical services can be reduced by providing free, accessible preventive and primary care as is done in Canada.

(continued)

Summary: Activity 3

7. Although the U.S. has more high technology, it doesn't mean better care is provided. One study showed that although the U.S. uses more invasive cardiac treatment than does Canada, the rates for death and second heart attacks are equal in both countries.
8. Canadians have better drug coverage. Prescription drugs are free if administered in the hospital. Most Canadian provinces provide universal drug coverage for the elderly, poor and disabled (with user fees in some cases) and some provinces provide universal drug coverage for all its citizens (with user fees).
9. Canadians' health is not compromised by waiting times. Although there are differences in waiting times for some non-emergency surgeries, Canadians do not wait for care that is urgent.
10. The Canadian national health program is financed through progressive taxation, government subsidies and, most significantly, from money saved from public administration of the program.
11. One of the reasons Canada can guarantee health care to all is because of the vast amounts of money saved from public administration. The United States spends $4,270 per person (Canada spends half that amount) because of the private sectors' enormous administrative costs and profiteering.
12. The Canadian health care delivery program is not socialized medicine. Doctors are paid on a fee-for-service basis and are free to practice where they choose. The government merely administers the program but does not provide any medical care. In much the same way that Canada provides its health care, the United States has "socialized" various services – such as police protection, fire departments, postal services, and social security.

Footnotes:

Activity 3: The Canadian Health Care System

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2. Martha Livingston, "Update on Health Care in Canada: What's Right, What's Wrong, What's Left," *Journal of Public Health Policy*, v. 19, no. 3, 1999, p. 33.
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5. Ironically, Saskatchewan doctors became the highest paid physicians in Canada by 1963 because they had guaranteed payment, guaranteed employment and greatly reduced paperwork. Armstrong, Armstrong and Fegan, *Universal Health Care*, ibid, p. 19.
6. A 1999 study by a group of international business advisors concluded that Canada had the lowest business costs, relative to North America, Europe and Japan, due in large part to Canada's lower labor costs resulting from lower employee-sponsored benefits, especially medical insurance. Canada's Health Care System, *Health Canada*, cited in ibid.
7. Organization for Economic Cooperation and Development, *OECD Health Data 98: A Comparative Analysis of 29 Countries,* Paris: OECD 1998, as analyzed in Gerard F. Anderson and Jean-Pierre Poulier, "Health Spending, Access, and Outcomes: Trends In Industrialized Countries, *Health Affairs,* May/June 1999, pp. 178 – 192.
8. OECD, 1997 from Dr. David Himmelstein and Dr. Steffie Wollhandler, "For Our Patients, Not for Profits," 1998, Physicians for a National Health Program, Chicago, Illinois.
9. Organization for Economic Cooperation and Development, *OECD Health Data 98*.
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11. John Billings, et al, "Recent Findings on Preventable Hospitalization," *Health Affairs*, 1996, vol. 15, no. 3, p. 239.
12. Donelan, "The Cost of Health System Change."
13. Health Canada, "Canada's Health Care System."
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15. John C. Hornberger, Alan M. Garber, and John R. Jeffery, "Mortality, Hospital Admissions, and Medical Costs of End-Stage Renal Disease in the United States and Canada," *Medical Care,* 1997, vol. 35, pp. 686-700, as reported in *Physicians for a National Health Program Newsletter,* December 1997, p. 12.

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Footnotes:

16. Jean L. Rouleau et al, "A Comparison of Management Patterns After Acute Myocardial Infarction in Canada and the United States," *New England Journal of Medicine,* vol. 328, no. 11, March 18, 1993, pp. 782 – 783, cited in Himmelstein and Woolhandler, *For Our Patients, Not for Profits,* p. 107.
17. Armstrong, Armstrong and Fegan, *Universal Health Care,* pp. 73-78.
18. Source for both graphs: Health Action International (www.cptech.org/dprice); Public Citizen (www.citizen.org/hrg/publications/1446.htm); U.S. GAO (www.house.gov/bernie/legislation/pharmbill/International.html.) cited in the National Health Program Slideshow Guide, Physicians for a National Health Program 1998 & 2000 editions.
19. Milt Freudenheim, "Group Seeks to Counteract Drugmakers," *The New York Times,* June 30, 2000.
20. Sheryl Gay Stolberg and Jeff Gerth, "How Companies Stall Generics and Keep Themselves Healthy," *The New York Times*, July 23, 2000.
21. Elizabeth Mehren, "Bargain Drug Prices Spark Border Crossings," *The New York Times*, Dec. 4, 2000.
22. Robin Toner, "Bitter Partisan Fight Brewing Over Medicare Drug Benefits," *The New York Times,* April 5, 2000.
23. Commonwealth Fund 1998 International Health Policy Survey in Karen Donelan, et al, "The Cost of Health System Change: Public Discontent In Five Nations," *Health Affairs*, May/June1999, vol. 18, no. 3.
24. Marshall W. Raffel, ed., *Health Care Reform in Industrialized Countries*, University Park, PA: The Pennsylvania State University Press, 1997, p. 15., in Armstrong, Armstrong and Fegan, Op.cit., p. 57.
25. "Waiting Times for Knee-Replacement Surgery in the United States and Canada," *New England Journal of Medicine*, vol. 331, October 20, 1994, p. 16, as cited in Armstrong, Armstrong and Fegan, p. 56.
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27. *Toronto Globe and Mail*, August 10, 2000, reported in *Physicians for a National Health Program,* May 2001.
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30. Carey Goldberg, "For Many States, Health Care Bills Are Top Priority," www.nytimes, January 23, 2000.
31. Woolhandler and Himmelstein, "Administrative Costs in U.S. Hospitals," p.1.
32. Armstrong, Armstrong and Fegan, *Universal Health Care*, pp. 65-66.
33. U.S. Census Bureau, *Statistical Abstracts of the United States:* 1999, Table 675.
34. Eliza Bussey, "Nurses Rally to Head Off Shortages," Reuters Health, dailynews.yahoo.com, June 2, 2000.
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Activity 4 What Do We Do About Our Health Care System?

Purpose: To examine solutions to the problems in our health care system.

Our health care system is in trouble. The public is demanding that something be done about the rising costs, the abuses of managed care and the millions of uninsured. The solutions being offered range from piecemeal or incremental approaches such as expanding government programs and increasing access to private insurance, to a more comprehensive solution such as a national health insurance system similar to Canada's. This Activity groups the many individual solutions to health care reform into four basic categories and asks you to evaluate them.

There is one task in this Activity.

Task 1

In your small groups please answer the question below. Remember to choose someone who has not yet had a turn to take notes on the discussion in your group and to report it to the whole group.

Question

After looking over and discussing Factsheets 1 through 5, **what general approach to health care reform does your group support and why?**

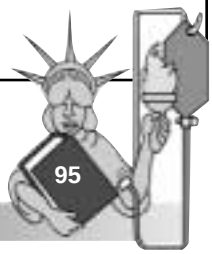
Factsheet 1

Four Approaches to Health Care Reform

Although there are many individual solutions to health care reform, they can be grouped into four basic types: 1) Employer-mandated; 2) Government Programs for All; 3) Access to Private Health Insurance; and 4) National Health Insurance. The chart below presents the four basic types of reform and examples of individual solutions and their limitations.

Four Approaches to Health Care Reform

Type of Reform	Features	Limitations
1. **Employer-Mandated** (See Factsheet 2)	Employers with certain number of employees must provide health insurance to employees working a certain number of hours.	Health care provided only to those with jobs; Health insurance industry and managed care delivery system remain intact; Encourages use of contingency workers and overtime; Doesn't challenge experience-rating; No consideration of future generations.
2. **Government Programs for All** (See Factsheet 3) • Expand Medicaid • Expand children's program • Extend Medicare to 55-65 year olds • Add prescription coverage to Medicare • Patients' Bill of Rights[1]	Approach that extends current government programs to more people – not just elderly and poor.	Health insurance industry and managed care delivery system remain intact; Increases bureaucracy; Affects small number of people at high added cost.
3. Access to Private Health Insurance (See Factsheet 4) • Tax Deductions • Tax Credits • Medical Savings Accounts • Pooling of small businesses (Health Plans & HealthMarts)	Programs that assist individuals and small businesses to obtain private health insurance.	Health insurance industry and managed care delivery system remain intact or even enlarged; Additional coverage adds substantial costs; Number of uninsured could increase; Affects small number of people.
4. National Health Insurance (See Factsheet 5)	Comprehensive health coverage for all U.S. residents from birth until death; Can choose doctors and hospitals; No bills, premiums or co-payments.	Overcoming vast lobbying efforts of the more than 1,500 profit-motivated, private insurance companies that control our health care system.



Factsheet 2

Employer-Mandated Insurance

Employer-mandated insurance requires employers with a certain number of employees to provide health insurance to those employees who work a certain number of hours per week. Currently, many employers offer health insurance, along with other benefits, although they are not required to by law. Those who advocate employer-mandated insurance must address the fact that many businesses are increasingly relying on part-time and contingent workers and cutting back on health and other benefits.

The 1998 Health Care for Working Families Act, sponsored by Senator Ted Kennedy, would have required employers with 50 or more full-time employees to offer health insurance, contribute 72 percent of the cost and pay a proportion of the cost for part-time workers working more than 10 but less than 30 hours per week.[2]

Limitations of Employer-Mandated Insurance

- **The health insurance industry remains intact.** This solution does not change the current delivery system of health care and its reliance on managed care. It does not address rising medical costs, limited access to care and the abuses of managed care. The costs to increase health coverage are particularly high since there are no cuts in profits or administration.
- **Affects only those with jobs, and has limited affects on the uninsured.** The 1998 Kennedy bill would have applied to an estimated 15 million uninsured people. Job-based solutions don't help the millions of uninsured who are unemployed and poor. Employer-mandates continue to subject the near-poor to demeaning means-tests programs.

(continued)

Factsheet 2

- **Shifts costs to workers.** Benefits that are tied to an employer are subject to change. Employees have no control over the increases in the cost of premiums, co-payments and deductibles. Today, employees are assuming more and more costs of health care.
- **Doesn't challenge worst feature of insurance industry: experience-rating.** The insurance industry is based on a practice called "experience-rating, " whereby different groups of people are assigned different insurance rates based on a determination of their health risks. The insured are put into hundreds of risk pools with vastly different premium costs. Large employers can garner better insurance deals. Experience-rating is in opposition to community-rating (the basis for National Health Insurance) which puts everyone in the same risk pool and keeps the cost of health care affordable for all.
- **Puts full-time jobs in jeopardy; increases reliance on contingency workers.** Employer-mandated coverage encourages employers to refrain from hiring full-time workers and rely on contingent workers or compulsory overtime rather than hire new workers and provide health insurance. Since the 1970s, employers have relied increasingly on part-time and contingent workers.
- **What about your kids?** An employer-mandated solution might be okay for those who have great job-based health plans. But there is no guarantee that just because you have a Cadillac plan that when your children join the workforce they will have the same coverage you have.

(continued)

Factsheet 2

Background:

Employer-provided benefits, including health care, have a long history. Employer-provided benefits got its impetus during WWII when many employers, not wanting to pay wartime excess taxes on their profits, provided benefits, which were tax-free. Benefits also attracted workers during wartime's tight labor market. After the war, labor made collective bargaining over social benefits a priority, as a way to protect union members and secure loyalty and members.

It wasn't until 1971 that the idea of employer-mandated insurance as a way to address the growing number of uninsured was first introduced – by the Nixon Administration. This proposed solution has surfaced again and again – in the Carter, Ford and Clinton administrations. One of the most recent attempts was the 1998 Health Care for Working Families Act. Hawaii is the only state with employer-mandated insurance, but over 11 percent of its residents remain uninsured. Massachusetts passed such a plan in 1988, but it was never implemented because of high costs.

Factsheet 3 Expanding Current Government Programs

Expanding current government programs is an incremental approach to providing health care coverage to more people. There are several solutions in this category:

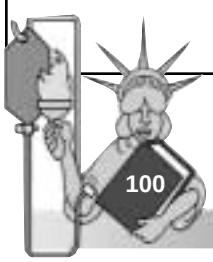
- ❒ **Expand Medicaid.** To expand Medicaid to all adults with family incomes below the poverty line ($17,000/year for a family of four).
- ❒ **Expand CHIP to parents and children.** To expand the government programs, Medicaid and The State Children's Health Insurance Program (CHIP),[3] to the parents of children who are already eligible for these programs. And to extend CHIP to children (not parents) in families with incomes up to around $42,000 for a family of four.
- ❒ **Extend Medicare to 55 to 65 year olds.** The government would provide "early buy-in" subsidies to help uninsured retirees get coverage.
- ❒ **Add prescription coverage to Medicare.** There are two plans: Coverage would be fully integrated into Medicare which would negotiate price discounts for all. Or, the government would funnel money to private insurance companies who would individually negotiate with drug companies and offer different drug benefits, premium costs and co-payments.
- ❒ **Legislate a Patients' Bill of Rights.** While the House of Representatives and the Senate are currently debating a bill on patients' rights, many states have already enacted laws that define patients' rights. Although the state laws and bills vary, they include issues such as requiring HMOs to reimburse providers who treat patients in emergencies; prohibiting gag clauses that say doctors can't discuss all treatment options with patients; allowing patients to sue HMOs for malpractice; allowing patients to appeal denials or treatments to outside experts, allowing women to see ob-gyns without prior approval.[4]

(continued)

Factsheet 3

Limitations to Expanding Current Government Programs

Program	Limitations	Background
Expanding Medicaid and CHIP	• Recent government study says program would assist only 6 million of 44 million uninsured.[5] • Parents often shun the stigma of government programs, therefore don't enroll children. • Medicaid and CHIP are administered through managed care, calling into question the quality of care provided. • Dependent on state's participation for success, which includes overcoming problems that caused CHIP to be less than successful in the first place. • Programs require frequent, cumbersome proof of eligibility, causing many eligible families to drop out.	Medicaid eligibility for parents typically stops after family's income reaches 60 percent of poverty line (about $10,200 for family of four). Proposed solution extends this. Most children with incomes below 200 percent of poverty are eligible for Medicaid or CHIP. But programs have been unsuccessful in enrolling children – 2.8 million low-income children still don't have health insurance. Pilot programs in Oregon, Hawaii and Tennessee suggest enrolling parents is helpful.[6]
Extend Medicare to 55-65 Year Olds	Estimates are that this solution would help only about 400,000 people.[7]	Medicaid eligibility starts at 65 years. Early retirees often don't have, and can't get coverage due to serious health problems.
Add Prescription Coverage To Medicare	Relying on private health plan carries risk. Witness HMOs dropping almost 1 million Medicare elderly by end of year. Encourages companies to seek out elderly with lower drug costs (cherrypicking). Government would be subsidizing insurance companies without any control over drug prices. Both plans have significant out-of-pocket costs.	Medicare covers basic medical services, but not out-patient prescriptions. More than one-third of all Medicare beneficiaries, about 14 million, lack prescription coverage and must pay out-of-pocket.[8]
Patients' Bill of Rights (any solution that retains managed care will need a Patients' Bill of Rights)	• Increase number of uninsured. The increased costs of Rights Bills to managed care companies will be passed on to employers. Employers may either drop coverage or increase costs of coverage, causing some employees to forego insurance. • Rights Bills will require another level of bureaucracy, adding to costs.	Congress and many states have proposed legislation to stop or reduce HMO abuses. The current Republican bill in Congress favors managed care companies.



Factsheet 4

Increasing Access to Private Health Insurance

Solutions in this category help individuals and small business obtain private health insurance. This approach leaves the current health industry and managed care in place. Solutions that increase access to private health insurance include:

- **Tax deductions.** To provide a tax deduction for people who pay at least 50 percent of their privately purchased individual health insurance. The tax deduction would be phased in to 100 percent by 2007. According to current law, the self-employed can deduct 60 percent of their health insurance expenses from their income when filing their federal income tax. However, working people who do not get coverage through their employer and who buy their own coverage cannot deduct the cost of their insurance premium (they can itemize health expenses under certain circumstances).
- **Tax Credits.** There are numerous tax credit proposals, all aimed at reducing the number of uninsured. Most aim at making the cost of health insurance a refundable tax credit, similar to the Earned Income Tax Credit. The government would give individuals and families an amount of money in the form of a tax credit to be used to purchase health insurance. The credit may be paid directly to the chosen health insurance carrier instead of to the individual. If the family owes no income tax they would receive the amount as a direct payment. Tax credit proposals vary considerably, with credits ranging from $500 to $2,800 per individual. The target population ranges from low-income people, to only those without employer coverage, to all regardless of income.[9]

(continued)

Factsheet 4

- **Medical Savings Accounts.** Medical savings accounts allow individuals to buy cheap insurance plans that cover only catastrophic illness and then put money aside, tax free, to pay for their out-of pocket medical expenses. If there is money left over when they turn 65 years of age they get to keep it. The theory behind this solution is that it will encourage frugal health care spending. An individual or family qualify for an MSA if the plan they choose has a high deductible – between $1,500 to $2,250 for an individual and $3,000 to $4,000 for a family. Participants put up to 75 percent of the deductible cost into a tax-deferred medical savings account, similar to an Individual Retirement Account. They pay their medical bills from this account. [10]
- **Association Health Plans.** These plans allow small businesses to pool together and bargain as a group for health care coverage. The pool is administered by an organization such as a local Chamber of Commerce (the sponsoring organization must have been in existence for three years and for purposes other than providing health coverage).[11]
- **Health Marts.** Marts are nonprofit organizations that contract with insurance companies to purchase insurance coverage for the employees of small businesses in a specific geographic area. The Health Mart acts as the coordinator and administrator.

The chart on the next page presents the limitations of each of the above solutions and some background information.

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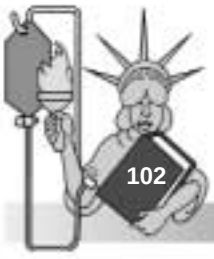

Factsheet 4

Increasing Access to Private Insurance

Program	Limitations	Background
Tax Deductions	Don't help low-income families who are uninsured and owe no taxes. The Joint Tax Committee estimates that only 320,000 of the 44.3 million uninsured would obtain insurance coverage under this proposal at a cost of $8 billion.[12]	Currently only the self-employed can deduct 60 percent of their health insurance expenses from federal income tax. The employed who purchase their own coverage can't deduct premium cost.
Tax Credits	**Tax credit too low**. Family health insurance premiums can cost over $6,000 a year. The credits won't be useful to low-income people unless they cover most of premium cost. **Subsidy for insurance industry**. Tax credits to subsidize health amounts to a huge government subsidy for the insurance industry which retains control of costs and delivery. **Lead to decline in employer coverage**. Employers could suspend health coverage if their employees were eligible to pay for insurance with tax credits. Individuals with serious health problems may not be able to find, or afford, coverage on their own. **Increase, not decrease number of uninsured**. If tax credits are available to those with employer-coverage, healthier employees may search for lower-cost plans on their own, driving up the cost of premiums for those more at risk who remain. Higher cost premiums may force people to drop or not seek insurance. **May not lower number of uninsured children.** Tax credit proposals do not mandate that parents buy coverage for their children.	This solution appeals to many because it uses the existing tax code.

(continued)

Factsheet 4

Increasing Access to Private Insurance

Program	Limitations	Background
Medical Savings Accounts	**Aimed at the wealthy.** Most available to those who have discretionary income and who can pay high deductibles. **Doesn't help uninsured**. The Internal Revenue Service states that 78 percent of those using MSAs in 1998 had prior health insurance coverage, suggesting that MSAs are not reducing the number of uninsured.[13] The IRS estimated that only 10,000 out of 44.3 million uninsured would use MSAs.[14] **Increases cost of premiums for rest of us**. Healthier people are drawn to MSAs because they expect few medical costs and see it as a way to shelter income from taxes. By taking the healthiest out of the broader insurance pool, MSAs will drive up the costs for those outside these accounts. **Provide pools of funds for physicians**. MSAs, which are supported by the American Medical Association, will provide pools of money for physicians to dip into without any restrictions on fees or quality of care.[15] **Don't protect MSA holders from financial risk**. If those with MSAs develop a major medical problem, they could face financial problems since the catastrophic plans that back up MSAs do not cover the out-of-pocket expenses that would accrue once the MSAs were used up**. Discourages preventive care.** Since MSA holders pay for care out-of-pocket, they may not seek medical care until a problem becomes serious.	In 1996 Congress created Medical Savings Accounts as a pilot project aimed at small businesses and self-employed workers who traditionally do not have access to group coverage. Congress mandated that 750,000 MSAs could be opened. The pilot program is ending this year and both the House and Senate have passed bills that would expand MSAs.

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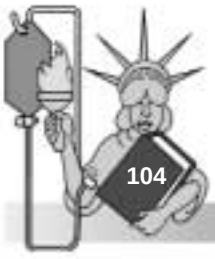
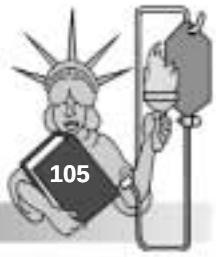


Factsheet 4

Increasing Access to Private Insurance

Program	Limitations	Background
Association Health Plans & Health Marts	**Exempt from state laws**. Both plans cut their costs because they are exempt from state laws that require all health plans to offer certain benefits such as mental health services and home health care. **Fragments insurance pool**. Plans can design their benefits packages to attract healthier people, discouraging sicker people from joining. By shunning state laws and offering fewer benefits, they can shut out those who need broader benefits and who will have to pay more for coverage. **Drive up premium costs for 20 million.** The Congressional Budget Office estimates that 20 million people will have their premium costs rise.[16] **Redlining**. Because Marts operate in specific geographic areas, they could seek out areas with healthier, more affluent populations. **Only 330,000 of uninsured affected.** The Congressional Budget Office estimates that only 330,000 out of 44.3 million uninsured will gain coverage through Plans/Marts.[17]	Business feels that Health Plans and Health Marts can help the uninsured by bringing down costs and making it easier to purchase insurance just as well as the government. Health plans have been pushed for years by the National Federation of Independent Business.[18]



Factsheet 5 National Health Insurance

National Health Insurance makes health care a right for every citizen. Comprehensive health care would be provided from birth until death for all U.S. residents – whether they are working, retired, laid-off, in school or between jobs. Similar to the Canadian system, the federal government is the insurer but the delivery system is private – it is not socialized medicine. Everyone can choose their own doctors, hospitals and other heath care providers. The care covered includes: doctor visits, nursing home and long-term care, hospitalization, preventive and rehabilitative services, access to specialists, prescription drugs, mental health treatment, dental and vision services, occupational health services, medical supplies and equipment.

The plan would be administered on a state-wide level. Physicians receive payment from the government based on negotiated fees for different treatments. Hospitals receive budgets based on past services.

Benefits of National Health Insurance:

- ❒ **One risk pool.** A national health program is based on one risk pool for everyone in the United States. It eliminates experience-rating. It puts everyone in the same insurance pool under one set of rules.
- ❒ **Cuts administrative costs.** The bureaucratic waste associated with over 1,500 private insurance companies is eliminated. With the government being the "single-payer," administrative costs are cut dramatically. The money saved can be directed exclusively to medical care.
- ❒ **Freedom from uncertainty.** People don't have to worry about getting quality medical care or prescription drugs or that they will be financially ruined because their health plans don't cover certain treatments.

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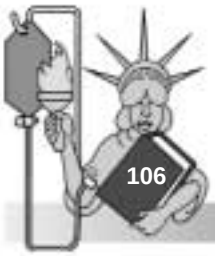

Factsheet 5

- ❒ **Freedom to change jobs and to organize without fear.** Often, workers are reluctant to change jobs or organize over unfair working conditions because they fear losing their jobs and their health coverage. National health care severs the connection between work life and health coverage.
- ❒ **More choice, fewer hassles.** People can go to the health-care provider of their choice.
- ❒ **More privacy.** With everyone enrolled in one system, there is no need for private insurance companies to check medical histories, life styles, employment status, financial ratings, etc. to determine program eligibility.
- ❒ **Eliminates paper work and hassles with insurance companies.** Under a national health care system, you walk into a doctor's office of your choice. No money changes hands. There are no premiums, no deductibles, no co-payments no restrictions on which services are covered. You never receive a bill or wait to be reimbursed.
- ❒ **Eliminates profits.** It eliminates profit-making as the operating goal. The provision of quality health care for all U.S. residents becomes the goal.
- ❒ **Lower pharmaceutical costs.** A single-payer system can negotiate substantial discounts from pharmaceutical companies by buying in bulk.

(continued)

Factsheet 5

Background:

The call for a national health insurance system in the United States has a long history.

- In 1939 Senator Robert Wagner sponsored the first legislative bill calling for national health insurance. Another legislative attempt was made in 1943 with the Murray-Wagner-Dingell bill which proposed to broaden the Social Security Act to include national health insurance. In 1945 President Truman proposed a program of national health insurance. Supporting all these legislative attempts were coalitions made up of labor unions, the medical community, advocacy organizations, and government.
- Truman's proposal was met with strong resistance from Senator Robert Taft and the American Medical Association (AMA), which mounted a huge public campaign, calling the bill socialistic. Associating national health insurance with socialism and communism was the tactic used by the AMA for many years. In fact, an advertising firm hired by the AMA falsely credited Lenin with saying, "Socialized medicine is the keystone of the socialist state."[19]
- In 1949, another legislative attempt for national health coverage made no headway due to efforts by the AMA, the American Dental Association, the American Pharmaceutical Association, and private insurance companies.
- In 1952, a new direction was taken with the proposal for a comprehensive health plan restricted to the elderly. After a concerted effort by labor, the public, advocacy groups and many in government, in the mid-sixties this plan resulted in the Medicare program.

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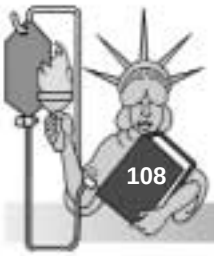

Factsheet 5

- In 1971, Senator Ted Kennedy (D-MA) introduced the Health Security Act which met much resistance from business and the insurance industry. This was the last legislative attempt for a national health insurance system.
- In 1976, President Carter endorsed a national health insurance system during his campaign, but did not follow through once elected.
- In 1993, President Clinton introduced a proposal for comprehensive health-care reform which focussed on managed competition. It did not receive support from the left or the right. In the absence of demands for national health insurance, legislators now focus on incremental or piecemeal approaches to increase some people's access to health care.

Summary: Activity 4

1. The public is demanding health care reform because the abuses of managed care can no longer be tolerated, the number of uninsured cannot be ignored, and costs to individuals and families are rising.
2. The many different solutions to health care reform can be grouped into four main categories: employer-mandated insurance; expanding current government programs to more people, not just seniors and the elderly; providing access to private health insurance, and a national health insurance program.
3. Employer-mandated insurance ties health care to jobs. It doesn't provide health care for the unemployed or the poor. It can't guarantee health coverage for future generations. And it leaves the health care industry intact with all its problems.
4. Expanding current government programs, another incremental approach, cannot provide comprehensive and affordable health care for all. Expanding government programs will help limited numbers of people, and will retain all the problems that come with relying on managed care. An example: the children's program, CHIP, was initiated to cover greater numbers of children because Medicaid wasn't covering low-income children. However, today, in spite of CHIP, the number of uninsured children has increased.
5. Providing access to private insurance to more people through programs such as tax credits/deductions, medical savings accounts and pools for small businesses is another band-aid approach that leaves in place the current health care structure with all its problems. These solutions will help small numbers of people, have the potential to reduce employer health coverage, increase the number of uninsured, and drive up premium costs.

(continued)

Summary: Activity 4

6. National health insurance is the alternative that has always made sense to many Americans. It provides a fundamental change in how health care is delivered to all – it is not merely a band-aid approach. It makes health care a right of every person. It breaks the unequal and tenuous relationship between families' health care, the employer and the condition of the economy. It eradicates profit-making and cost-cutting as the rationale for health care decisions. It places medical decisions back in the hands of physicians and their patients.

Footnotes:

Activity 4: What Do We Do About Our Health Care System?

1. Any solution that retains managed care will need a Patients' Bill of Rights, including solutions 1-3 above. Technically, a Patients' Bill of Rights is not a government program. It was put in this category, because relative to the other solutions, it would be a government legislated policy.
2. www. senate.gov/ma/kennedy/universal health security.
3. CHIP was initiated in 1997 when Congress provided $40 billion over ten years to help states provide health insurance to children whose families earn too much to qualify for Medicaid but too little to afford private insurance.
4. See, for example, the 1999 bill sponsored by Rep. Charlie Norwood (R-GA) and Rep. John Dingell (D-Mich.).
5. The President's Council of Economic Advisors, "Reaching the Uninsured: Alternative Approaches to Expanding Health Insurance Access," September 2000.
6. Leighton Ku and Matthew Broaddus, *The Importance of Family-Based Insurance Expansions: New Research Findings about State Health Reforms*, Washington, D.C.: Center on Budget and Policy Priorities, September 5, 2000.
7. David Nather, "Beyond Band-Aids: Why Incremental Reform Can't Solve Our Health Care Crisis," *Washington Monthly*, January/February 2000, www.washingtonmonthly.com.
8. The League of Women Voters and The Henry J. Kaiser Family Foundation, *Join the Debate: Your Guide to Health Issues in the 2000 Election*, pp. 21-25.
9. Consumers Union, "Tax Credits and the Uninsured," Letter to Members: Summary of Proposals, March 11, 1999.
10. Gail Shearer. "Medical Savings Accounts," Consumers' Union Fact Sheet, July 16, 1998.
11. Families USA, "Association Health Plans," New Patients' Bill of Rights Fact Sheets, February 22, 2000
12. Families USA, "New Tax Deductions for Individuals," New Patients' Bill of Rights Fact Sheets, February 22, 2000.
13. Howard Gleckman, "The Nasty Side Effects of Medical Savings Accounts," *Business Week,* October, 25, 1999.
14. Families USA, "Medical Savings Accounts" New Patients' Bill of Rights Fact Sheets, February 22, 2000.

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Footnotes:

15. Don R. McCanne, "Symposium: Would Single-Payer Health Insurance Be Good for America?" *Insight*, March 27, 2000, reprinted in Physicians for a National Health Program Newsletter, September 2000.
16. Families USA, "Health Marts," New Patients' Bill of Rights Fact Sheets, February 22, 2000.
17. Families USA, "Health Marts."
18. David Nather, "Beyond Band-Aids."
19. Edmund Wehrle, "For a Healthy America: Labor's Struggle for National Health Insurance, 1943-1949," *Labor's Heritage*, Summer 1993, p. 40.

Activity 5 Just Health Care: Is It Good for Working People?

Purpose: To determine if national health insurance is a workable solution for the United States. Is it just another big government program? Can we afford it?

There are two tasks in this Activity.

Task 1

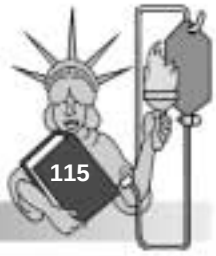
Please read the statement below and answer the question that follows. Remember to choose a different group note-taker. Please complete Task 1 before moving on to Task 2.

Statement

A national health insurance program is just another big government program. It means "more government," more levels of bureaucracy and is wasteful compared with the efficiencies of the private market.

Question

Do you agree or disagree with this statement? Why or why not? When answering this question please look over all the factsheets – but especially Factsheets 1 and 2.



Task 2

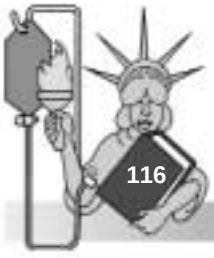
Please read the following statement and answer the question that follows. Choose another person to be the note-taker and reporter.

Statement

National health insurance sounds great – in fact, too good to be true. One of the big reasons national health insurance never got anywhere in the past is because everybody said it just costs too much. That still holds true today. Who's going to pay for it? Everyone's taxes will have to go up. Workers' premiums will increase. Employers will have to contribute a lot more than they do now. Today, some employers don't even offer health insurance so they don't have any of those costs. And if private insurance gets eliminated with a national health insurance program, thousands of people will lose their jobs. What's going to happen to them? A national health insurance system just sounds too expensive.

Question

Do you agree or disagree with the statement above? Why or why not? Please refer to Factsheets 3 through 13 when formulating your answer.



Factsheet 1

National Health Insurance Means Less Bureaucracy; More Money for Direct Care

The United States spends $4,443 per person on health care. Canada spends half as much – $2,250 – and guarantees health care for all its citizens.[1] One of the main reasons for this difference in spending is the enormous administrative costs associated with the privately-run health care system in the United States.

In the U.S., every doctor's office, every clinic, every hospital has its own administrative bureaucracy, as does every one of the over 1,500 private insurers, resulting in much duplication of administrative efforts. Much of our health care experience is defined by administrative hassles. In Canada, because everyone is enrolled in the same plan with a single payer, doctors and hospitals do not need to keep detailed financial accounts for numerous insurance companies, send patients bills, or determine who is or isn't eligible for Medicare.

As the chart below shows, it is estimated that the U.S. spends about $1,080 per person maintaining our health care bureaucracy. Canada spends a little less than one-fifth of this amount. The chart also shows that Canadian hospitals and doctors' offices spend considerably less on administration due to a single payer system.

U.S. Administrative Costs Much Higher Than Canada's, 2000

Country	Overall Health Care Administrative Costs	Hospital Billing & Administration	Doctors' Billing & Office Expenses
United States	$1,080/person	$372/person	$430/person
Canada	$223/person	$68/person	$102/person

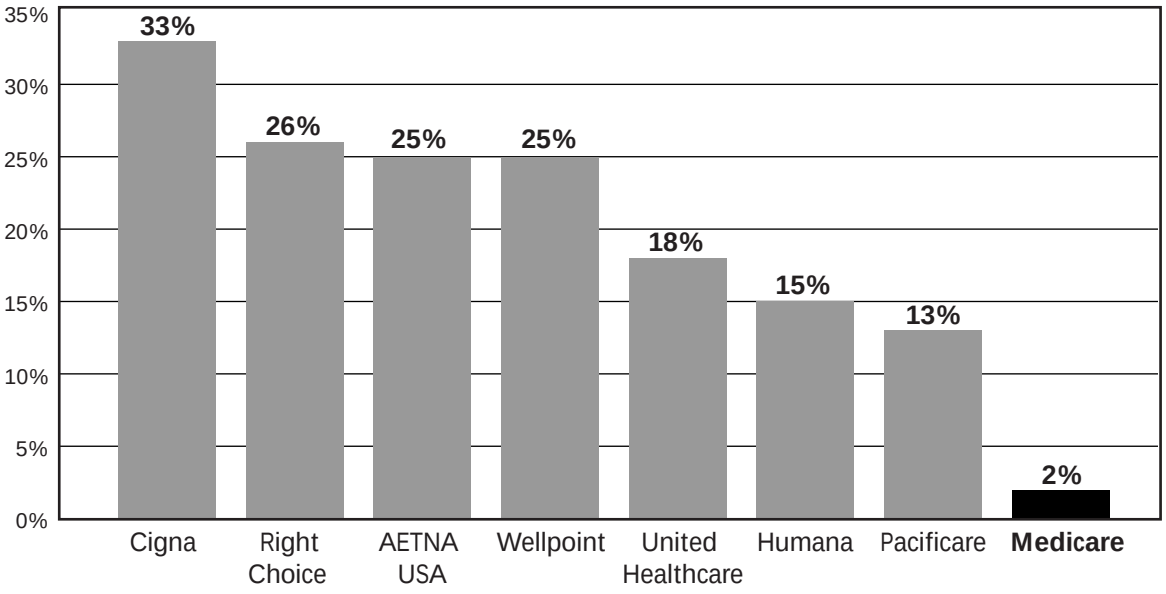
Factsheet 2

Government-Run Program Not Wasteful

Many say that government bureaucracies are wasteful compared with the efficiencies of the private market. But in the delivery of health care this just isn't true. Our Medicare program is a publicly administered program with administrative costs just above 2 percent. Compare this with managed care which consumes up to 33 percent of health-care premium costs for overhead and profits. See the chart below.

The privately-run managed care companies require networks of administration, much duplication, and huge marketing efforts. All of these costs would be unnecessary in a single payer system where the sole use of funds is to optimize patient care.

Percent of Premium HMOs Take for Their Overhead and Profits



Factsheet 3 How Is Our Current Health Care Paid For?

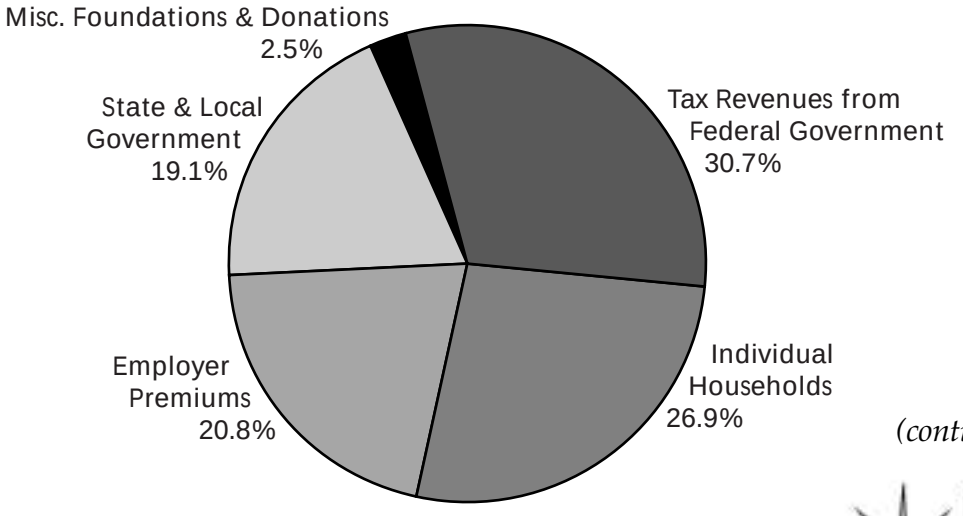
In 1999, the United States spent approximately $1.2 trillion on health care. This means that almost 13 percent of the economy was spent on health care – an average of $4,443 per person – for items such as doctors, prescriptions, hospital care, administration and medical supplies. Every other industrialized nation provides comprehensive care for everyone for only 6 to 10 percent of their total economy.

Our Taxes and Out-of-Pocket Costs Finance Most of Our Health Care

As the pie chart below and the chart on the next page show, almost half of the money for health care in the U.S. (49.8%) comes from tax revenues levied by the government; individuals pick up almost 27 percent in out-of-pocket costs; business contributes about 21 percent, with a small amount (a little over 2 percent) coming from donations and foundations. See next page for detailed breakdown.)

Current Financing of U.S. Health Care System 1999 Estimates

Our taxes and out-of-pocket costs pay for 77 percent of U.S. health care.



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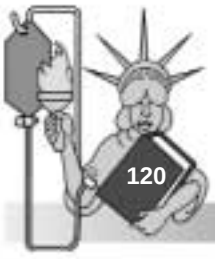
Factsheet 3

Current Financing of U.S. Health Care System

Program	Amount
Tax Revenues from the Government: Money from many different taxes fund government programs such as Medicare, Medicaid, public health programs, health care for government and military workers and medical research. Tax revenues come from:	
1. Federal Programs	
Medicare Payroll Tax (1.45% on each employee & employer)	$121.0
Employer contribution to Medicare for federal workers	2.8
Health insurance premiums for federal workers	13.8
Medicaid & additional Medicare	185.0
Public health programs	49.7
Total	**$372.3 billion**
2. State & Local Programs	
Health insurance premiums for state & local employees	$57.5
Employer contribution to Medicare for state/local employees	6.8
State share of Medicaid and other services	127.5
3. Federal/State/Local Hospital Construction & Research	40.4
Total	**$232.2 billion**
Funds from Business: Employers contribute to employee health care premiums, worker compensation and company in-patient facilities.	
Employee health insurance premiums	$224.5
Workers compensation	23.6
In-patient health facilities	4.0
Total	**$252.1 billion**
Money Paid by Individuals: Individuals pay for their health care premiums, co-payments, Medicare Part B premiums and out-of-pocket expenses.	
Premiums	$83.7
Part B Medicare Premiums	19.9
Out-of-pocket spending	223.1
Total	**$326.7 billion**
Other Revenues: This includes donations from individuals, foundations and money from hospital gift shops.	**$30.2 billion**
Total Amount of Money That Finances U.S. Health Care System:	**$1.213 trillion**



Factsheet 4

Can We Afford National Health Insurance?

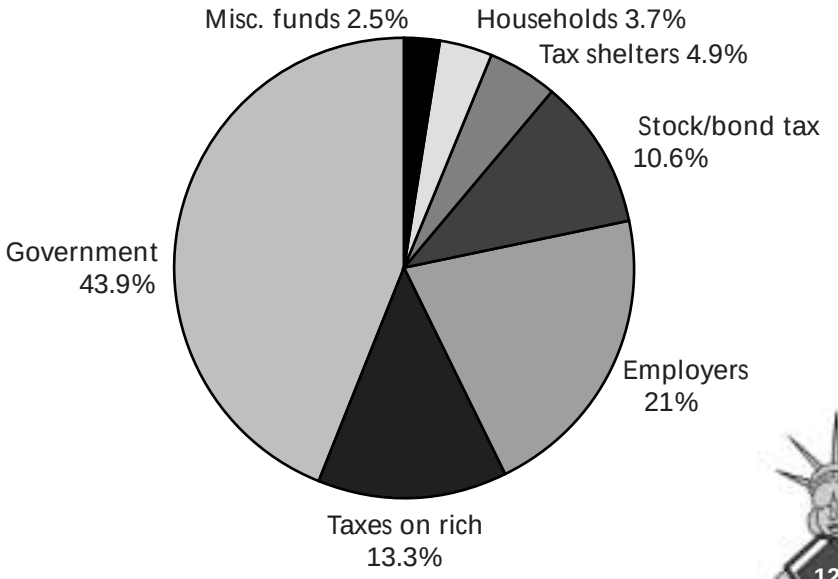
Every other industrialized nation provides comprehensive medical care to its citizens at a much lower cost than our system, which has millions of uninsured. We already have enough funds in the United States to provide quality care for everyone.

How Can We Pay for a National Health Insurance Program? By eliminating the high administrative costs and profit in our current health care system, and by having the wealthy pay their fair share, **the United States can provide comprehensive health care to every U.S. resident for the same total amount of money that we now spend** – an estimated $1.213 trillion.

The revenues will come from the government, employers, income taxes on the wealthy, taxes on stock and bond transactions, the budget surplus, closing corporate tax loopholes, households, and existing donations. The pie chart below shows the percentage contributions from each source. (See next page for detailed breakdown.)

Financing National Health Insurance

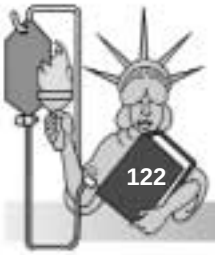
We will call this financing approach to national health insurance and the program itself, "Just Health Care."



Factsheet 5

Financing Just Health Care

Source of Funds	Amount in billions
Tax Revenue from the Government: Keep existing federal, state and local tax revenues that currently go to Medicare – from employer and employee payroll taxes – and other state and federal programs. The revenues that now pay government workers' health premiums would be subtracted.	$533.3 billion
Employers: Implement a 5.5 percent tax on the payroll of all public and private employers ($4.6 trillion). Keep existing employer expenditures for clinics run by corporations ($4 billion). Employers currently offering health care will save money while employers currently offering no or few benefits will see their costs rise. However, the yearly employer cost on the average wage of $28,861 will be $1,587.36. See Factsheet 7 for more information.	$255.1 billion
Income Taxes on the Wealthy: The wealthiest Americans should pay their fair share. An additional 5 percent income tax would be levied on those taxpayers with average incomes of $183,200, and a 10 percent income tax on the richest one percent – those with average incomes of $763,200. These two taxes are on income only, not on unrealized capital gains in stocks, bonds, home sales.	$161.9 billion
Tax on Stock and Bond Transactions: Anyone who purchases a stock will pay a transaction tax equal to one half of one percent of the purchase price. For those who invest and hold on to stocks, the tax will be minimal. For example, a $100 stock purchase will be taxed 50 cents. See Factsheet 10 for more information.	$128.4 billion
Closing Corporate Tax Shelter Loopholes: Corporate taxes are not rising with their increasing profits because companies have found all sorts of ways to shelter their money. According to a recent study, between 1996-1998 corporate profits of the 250 large corporations studied soared 23.5 percent. But 41 of these companies paid no federal income taxes. These companies reported profits of $25.8 billion.[5]	$60 billion
Households: Would no longer have to pay for premiums and co-payments, Medicare Part B and all out-of-pocket costs for services currently not covered like dental, vision care and prescriptions. Under national health care, households will have to pay for things like over-the-counter drugs and elective cosmetic surgery. See Factsheet 8 for more information.	$44.6 billion
Existing Revenues from Individuals & Foundations	$30.2 billion
Total Amount of Money to Finance Just Health Care	**$1.213 trillion**



Factsheet 6

Compare the Financing

Our Current Health Care System:

We pay for our health care twice – from our taxes and from our out-of-pocket spending.

Source of Funds	Amount in Billions	Percent of Total
Government tax revenues	$604.5	49.8%
Households' out-of-pocket expense	$326.7	26.9%
Employer's payments for premiums & worker's comp	$252.1	20.8%
Foundations	$30.2	2.5%
Total	**$1.213 trillion**	100%

Just Health Care: A National Health Insurance Program

We will pay for health care for all primarily from our taxes and from the wealthier paying their fair share.

Source of Funds	Amount in Billions	Percent of Total
Government tax revenues	$533.3	43.9%
Employer 5.5% payroll tax	$255.1	21%
Income tax on wealthiest 5% of taxpayers	$161.9	13.3%
Tax on stock & bond transactions	$128.4	10.6%
Closing of corporate tax shelter loopholes	$60	4.9%
Household out-of-pocket	$44.6	3.7%
Donations/foundations	$30.2	2.5%
Total	**$1.213**	99.9%

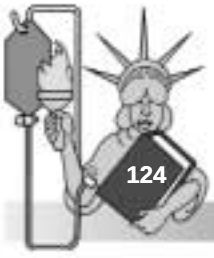
Factsheet 7

What Employers Will Pay

Employers will be taxed 5.5 percent of their payroll – for a total of $255.1 billion.Today, many employers pay more than 5.5 percent of their employee's health care benefits; some pay less; and some employers don't offer health benefits at all. Under Just Health Care, all employers will pay 5.5 percent of their payroll to cover the costs of health care for everyone.

This means that those employers who paid more than 5.5 percent of their payroll for health care will incur less costs, while those who paid less than 5.5 percent, or didn't offer any health benefits, will see their costs rise. For example, the annual employer cost on the average wage of $28,861 will be $1,587.36. This is a modest sum given the fact that, currently, the average annual premium, shared by employers and employers is $2,650 for single coverage and $7,053 for family coverage.

Factsheet 11 discusses how a portion of the "savings" from those employers who currently pay more than 5.5 percent will be used to assist the administrative workers in the health industry who will loose their jobs.



Factsheet 8

What Most of Us Will Pay

In 1997, the average household in the United States spent $1,841 out-of-pocket on health care – premiums, co-payments, doctor and hospital bills, prescriptions and medical supplies. This is a $733 increase from 1985.[6]

As the chart below shows, employers shifted health care costs to employees, with rising health care costs.[7]

Percent of Employees Required to Contribute to Employer-Provided Insurance

(For those obtaining coverage through their employers)

Year	For Individual Coverage	For Family Coverage
1980	25% had to contribute	49% had to contribute
1995	66% had to contribute	80% had to contribute

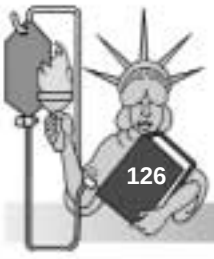
With a National Health Care system there will be no costs to individuals for premiums, co-payments, deductibles and many current out-of-pocket expenses.

Total household expenditures will drop from $326.7 billion to $44.6 billion annually. Income taxes will increase only for those with average incomes of $183,200 and above. **Ninety-five percent of taxpayers will save money.**

Factsheet 9

What the Wealthy Will Pay

The wealthiest Americans should pay their fair share. Only taxpayers with incomes above $183,200 will see their taxes increase. Taxpayers with average incomes of $183,200 will be taxed an additional 5 percent. Those with average incomes of $763,200 (the richest 1 percent) will be taxed an additional 10 percent. The tax is on income only and does not include stocks, bonds and property. **Ninety-five percent of taxpayers will save money.**



Factsheet 10

Tax On Stock and Bond Transactions

Another component of financing national health insurance is to tax stock and bond transactions. In 1997, about half of all households owned no stocks, not even mutual funds or pension plans such as IRAs, 401(k), 403(b) or Keogh plans. The wealthiest 10 percent of households owned 82 percent of all stocks, including those in mutual funds or pension plans. Fully 41 percent of all stock is owned by the richest 1 percent of households.[8]

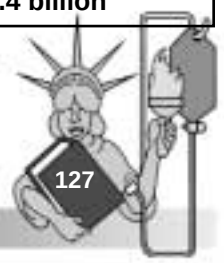
Minimal effect on most of us. Under Just Health Care, anyone who purchases a stock will pay a transaction tax equal to one half of one percent of the purchase price. For those who invest and hold on to stocks, the tax will be minimal. For example, a $100 stock purchase will be taxed 50 cents. If the stock is held for four years and sold for $125, the tax represents only two percent of the gain.

Speculators pay more. However, speculators who sell rapidly will pay more. If the same $100 stock is sold in two months for $101, the tax represents 50 percent of the $1 gain.[9] The chart below shows the expected revenue raised from stock and bond transaction fees.

Funds for Just Health Care from Stocks and Bonds Transaction Fees

Source	Tax Rate	Annual Revenue
Stocks .	25% each on buyer & seller	$36.5 billion
Government Bonds	.1%	$27.7 billion
Corporate Bonds	.1%	$14.7 billion
Futures Contracts	.02%	$13.3 billion
Currency	.1%	$33.3 billion
Swaps	.02%	$2.9 billion
Total		**$128.4 billion**

Source: Center for Economic and Policy Research, 2000



Factsheet 11 A Just Transition

The switch to national health insurance will mean a loss of some administrative jobs, but an increase in jobs in health care delivery, expanded public health programs, health promotion and education, and home care. The administrative workers will need a "just transition" to assist them. Under Just Health Care, a transition fund will be established to help workers retrain and find new jobs without a loss of income.

What Is A Just Transition?

A fund of money will be established to assist dislocated health care workers in a "just transition" to other employment. The fund will pay for:

- ❒ Full take-home pay and benefits for up to four years, or
- ❒ A four year wage subsidy for any worker who takes a job that pays less than the old job, and
- ❒ Full tuition for up to four years if the worker chooses to attend school.

(continued)

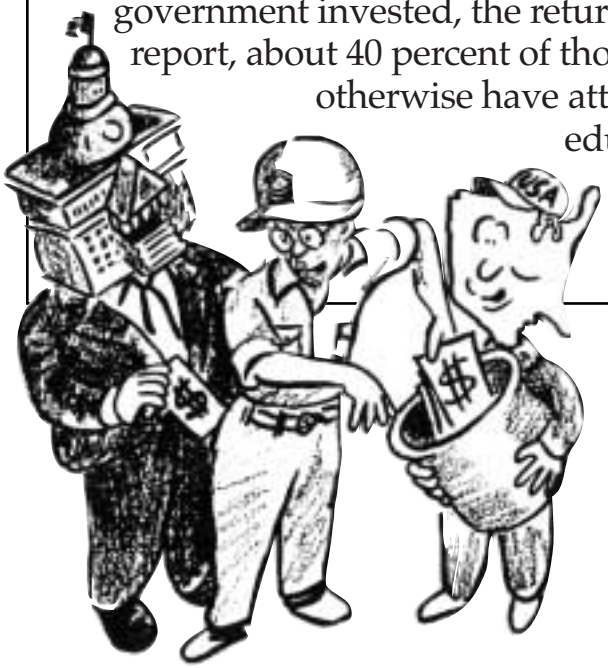
Factsheet 11

Funding Just Transition

The "just transition" will be funded, in part, by the amount of money "saved" by those employers who previously paid more than 5.5 percent of their payrolls for health benefits. The difference between what was paid previously and the amount paid with the 5.5 percent will be taxed over a specific time period as a windfall profit tax.

Example of a Successful Just Transition: The GI Bill of Rights

In 1944, Congress passed the GI Bill of Rights to address the possibility of mass unemployment with the return of millions of World War II U.S. veterans. The purpose of the bill was to pay returning veterans a living wage to attend school and included funds for tuition, lab fees, health insurance, supplies and up to $1,440 per year for expenses. A 1988 congressional analysis of the program showed it to be a success: for every dollar the government invested, the return was $6.90. According to the report, about 40 percent of those who participated would not otherwise have attended college.[10] The additional education led to higher wages for the GIs and more taxes for the government.



Factsheet 12 Why Employers Oppose Just Health Care

Many employers oppose national health insurance because they claim that it will drive up their costs and create more paperwork. However, two very significant reasons for employers' opposition to national health insurance involve issues of power and control.

National Health Insurance Takes Health Care Out of Bargaining

Employers value their control over their workforce, and job-based health care coverage gives them enormous control. One of the ways employers control their workforce is by threatening to take away, or reduce, their health care benefits. A national health insurance program would give workers more security and independence from their jobs and their employers. With national health insurance, workers have more freedom to move from job to job, to strike, and to take other work actions without jeopardizing their family's health. In no other country does a loss of job usually mean a loss of health care. The United States is the only country where health care is tied to employment status.

National Health Insurance Can Track Major Health Problems

A national health insurance program can facilitate a central repository of information on diseases, deaths and major illnesses by geographic area. Epidemiologists can examine such data and look for causation factors. With a national health insurance program, the possibility exists to link, with more certainty, health problems to the production practices of various corporations.

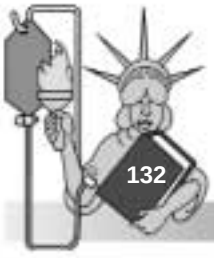
Summary: Activity 5

1. National health insurance will eliminate bureaucracy, not create it. A national health insurance program with the government as the single payer will eliminate the huge administrative costs and profits that divert money from quality medical services. Currently, the overall administrative costs of our insurance company dominated health care system are five times the costs of the single-payer Canadian system.
2. Government-run programs are not wasteful. Our Medicare program, which is a publicly run system, has administrative costs just above 2 percent. Compare this with the costs of managed care, where up to 33 percent of health care premium costs go for overhead and profits.
3. Our current health care system costs $1.213 trillion. We pay for most of our health care through our taxes and our out-of-pocket spending.
4. We can have national health insurance for the same cost ($1.213 trillion) by eliminating our privately-run system with its high administrative costs and profit and by having the wealthy pay their fair share.
5. Under Just Health Care, there will be no costs to individuals for premiums, co-payments, deductibles and many current out-of-pocket expenses.

(continued)

Summary: Activity 5

6. Ninety-five percent of taxpayers will save money. Only those with average incomes of $183,200 and above will be taxed an additional 5 percent. Those with average incomes of $763,200 and above will be taxed an additional 10 percent.
7. Just Health Care includes a fund for those workers in the health insurance industry who will lose their jobs with the elimination of private insurance. The Just Transition fund includes, full take-home pay and benefits for up to four years, or a wage subsidy for workers whose job pays less than the old one, or full tuition for up to four years.
8. Many employers oppose national health care because it gives workers more control over their jobs. By removing health care as a bargaining issue, workers are more free to change jobs and take work actions without jeopardizing their family's health care. A national health insurance program also can collect data on clusters of health care problems and determine possible links with the practices of corporations in the affected areas.



Footnotes:

Activity 5: Just Health Care: Is It Good for Working People?

1. Sources for data in Activity 5: see Activity 3, The Canadian Health Care System.
2. The calculations in Activity 5 are a joint effort by The Labor Institute and The Labor Party, Washington, D.C. The proposal for a National Health Insurance Program based on an employer payroll tax, taxing the wealthy, closing corporate loopholes, the budget surplus and a fund to assist displaced workers in the health insurance industry is a program of The Labor Party known as **Just Health Care**. See: Briefing Paper: Financing Just Health Care, June 2000, The Labor Party, Washington, D.C. 202-234-5190.
3. Average wage for 1998. National Average Wage Index, Social Security Administration, October 19, 1999 (www.ssa.gov).
4. Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2001-2010*, Congressional Budget Office, January 2000 (corrected January 2/1/00), Washington, D.C. (www.cbo.gov).
5. David Cay Johnston, "Study Finds That Many Large Companies Pay No Taxes," *The New York Times,* October 10, 2000. Study conducted by the Institute on Taxation and Economic Policy, Washington, D.C.
6. Average Annual Expenditures per Consumer Unit for Health Care: 1985 to 1997. Bureau of Labor Statistics, Consumer Expenditure Survey, annual, Table 184 in U.S. Census Bureau, *Statistical Abstract of the United States: 1999.*
7. Bureau of Labor Statistics, "Employee Medical Care Contributions on the Rise," *Issues in Labor Statistics,* Washington, D.C: U.S. Department of Labor, April 1998.
8. "The Bull Market: Is the Stock Boom a Bust for Workers?" *Paycheck Economics*, Washington, D.C.: Economic Policy Institute, May 1999, p. 3.
9 . Dean Baker, *Taxing Financial Speculation: Shifting the Tax Burden from Wages to Wagers.* Washington, D.C.: Center for Economic and Policy Research, February 2000.
10. *A Cost-Benefit Analysis of Government Investment in Post-Secondary Education Under the World War II GI Bill*, Washington, D.C., Subcommittee on Education and Health of the Joint Economic Committee, December 14, 1988.

Glossary

Cherry Picking
A practice whereby insurance companies, by tailoring their benefit packages, selective advertising or other practices, attract clients who are more healthy and less costly. An example: HMOs increased their profits by cherry picking the most healthy seniors on Medicare. But, over the last couple of years, many relatively sick seniors have joined HMOs in some regions. As a result, HMOs are now pulling out of these unprofitable regions, denying coverage to hundreds of thousands of senior citizens.

Experience-Rating
A practice used by the insurance industry whereby the health conditions of a particular group determines insurance rates for that group. Experience-rating took off after World War II when the health insurance market expanded rapidly. In an effort to undercut competitors, companies offered vastly different insurance rates to different groups depending on their health risks. Today, a myriad of risk pools exist, each with different priced premiums. Individuals and groups are put into these groups depending on their likelihood of requiring costly medical services. Experience-rating has opened the door to undesirable practices such as genetic screening, pre-employment screening, and penalties for employees with particular lifestyles. The "opposite" of experience-rating is community rating, whereby insurance rates do not vary much from one individual or group to another. A national health care program is based on community rating where everyone is placed in the same risk pool.

Health Maintenance Organizations (HMOs)
Prepaid group practices. Members are required to use in-network doctors and hospitals only. Most HMOs require authorization before certain medical services and hospital admissions are provided. A gatekeeper physician makes referrals to other doctors based on HMO rules. Premiums and co-payments tend to be the lowest in HMOs, relative to other plans. This was the original meaning, but many plans now called HMOs include other managed models, such as PPOs.

Managed Care
A general term for several types of coordinated health care delivery systems. Managed care plans involve oversight of the medical care, contractual relationship with and organization of the providers giving the care, and a list of benefits tied to managed care rules. The most common types of managed care are Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).

Preferred Provider Organizations (PPOs)
Networks of doctors, hospitals and pharmacies agree to reduced rates for their services. PPOs offer a wider range of doctors and less stringent rules about the availability of treatments than do HMOs. Employees can go to any doctor in the network without referrals, but premiums can be twice as expensive as an HMOs .

Traditional Fee for Service
Patients choose whatever physician they want to see and physicians can order whatever treatment services they choose. After the medical treatment is completed the health plan is billed and patients pay the difference between the physician's charges and what their health plan pays. Managed care was thought to be the remedy to control the spiraling costs of health care under traditional fee for service.